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HOSPITAL PROSPECTIVE PAYMENT SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

FEBRUARY 17, 1983

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HOSPITAL PROSPECTIVE PAYMENT SYSTEM

THURSDAY, FEBRUARY 17, 1983

U.S. SENATE,
SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 9:35 a.m., in room 2221, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger, Dole, Baucus, Bradley, and Long.

Senator DURENBERGER. The hearing will come to order.

Good morning, everybody, we are here today at this relatively early hour for Washington to continue our examination of the Secretary of Health and Human Service's proposal for prospective payment of hospital care under the medicare program.

On February 2, we heard the Secretary outline his proposal and discuss the needs for change away from the present cost based system and toward a system which rewards efficiency. We also heard from the hospital associations, representatives of those institutional providers directly affected by the proposed changes, and from States, which have experienced similar change as part of their efforts to control rising hospital costs.

Today we will hear from those groups and individuals who either directly or indirectly participate in providing quality care in the hospital setting. We look forward to hearing their concerns and their suggestions for improvement of the proposed prospective payment system.

The first person we will hear from is Dr. Jerald Schenken, representing the American Medical Association. He will be joined at the table, I understand, by Dr. Joseph English, chairman, Council on Standards of Practice and Economics of Health Care of the American Psychiatric Association, and chairman of the Department of Psychiatry, St. Vincent's Hospital and Medical Center, New York, on behalf of the American Psychiatric Association. And by Dr. Primich, the Medical Society of New Jersey, Lawrenceville, N.J.

And I understand Dr. Schenken will have a statement. Your formal statement will be made part of the record. You can read it, summarize it, as you choose, Doctor. And that Dr. English and Dr. Primich will be available for our questions.

Mr. Chairman, do you have any comments that you feel inspired to make?

Senator DOLE. I will put them in the record.

Senator DURENBERGER. Great. Thank you.

[The opening statement of Senator Dole follows:]

OPENING STATEMENT OF SENATOR BOB DOLE

I welcome the witnesses who join us today and look forward to continuing our discussion on the Administration's prospective payment proposal.

I found to the first hearing on this same subject which was held on February 2 to be particulary helpful to me in identifying the problems and difficulties with the prospective proposal. A number of excellent recommendations were provided to us by the witnesses that day, recommendations which we have continued to evaluate. I am hopeful that all of you who will present testimony today will add to this knowledge base.

As I indicated at the outset of these hearings, it is in all our best interests to try to reach a consensus on the issues before us. Clearly, cost-based reimbursement is a system whose time has come and gone, but that doesn't mean that we intend to simply jettison that system for another that won't work. Sure, I'm in support of the principle of prospective payment—but not if is means doing irreversible damage to the institutions in this country.

There are differences between institutions, legitimate differences that must be accounted for in any payment system. But that doesn't necessarily argue for maintaining the status differences and to adjust for them.

The differences in the severity of patient's condition is of concern to us. The impact on the nursing labor force of a prospective system, and on the quality care, is also of concern. We need some answers, not simply more questions.

I'm anxious to hear some of your answers.

Senator DURENBERGER. Dr. Schenken, please.

STATEMENT OF DR. JERALD R. SCHENKEN, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.

Dr. SCHENKEN. Thank you, Mr. Chairman.

Mr. Chairman, and members of the subcommittee, my name is Jerald Schenken, M.D. I'm a physician in the practice of pathology in Omaha, Nebr., and I am vice chairman of the AMA's Council on Legislation.

With me is Ross N. Rubin who is director of the AMA's Department of Federal Legislation.

The American Medical Association is pleased to have this opportunity to testify on the issue of prospective pricing for hospital services furnished to medicare beneficiaries. In the interest of time, I won't read my entire prepared statement.

The American Medical Association supports the development and exploration of systems for payment to institutions on the basis of predetermined rates or other payment systems that create incentives for facilities to be more cost conscious. In early 1978, the AMA adopted recommendations of the National Commission on the Cost of Medical Care calling for the exploration of systems for payment to institutions on the basis of predetermined rates, or other payment systems that create incentives for facilities to be more cost conscious. In accepting this recommendation, we pointed out that such systems should be implemented on a broad scale only if they prove to be effective.

It would be inappropriate to institute a radical change in the medicare hospital reimbursement system without assurances that quality of care can be maintained. To this end, we strongly caution against the implementation of any full scaled prospective pricing system without experimentation, and until ongoing projects have been analyzed to determine their effects on cost and quality.

Mr. Chairman, we have numerous concerns about the administration's proposal. Without question, a system can be devised to achieve any targeted level of cost savings within an existing system. We are concerned that any proposal, including the administration's, could reach that point where there would be an adverse effect on access and quality of care for medicare beneficiaries. Upon our review of the administration's proposal, a number of readily apparent problems relating to quality of care are raised.

The proposal fails to specify the methodology for establishing the uniform national rate. The proposal, unlike the New Jersey program, fails to recognize the legitimate variations in different institutions.

The proposal's use of DRGs as the case-mix adjuster fails to recognize variations in the intensity of the illness and the impact of complications with each of the DRGs, and the variations in services needed to address these cases.

The proposal does not contain any explanation of the methodology for determining outliers and it does not discuss the level of reimbursement for such cases.

The proposal would provide windfall reimbursement levels to some hospitals by providing them with reimbursement above the cost of providing services while causing substantial disruption of services in those hospitals whose actual costs were above the national average.

While the proposal does call for annual updates of DRG reimbursement, factors pertinent to the provision of care and central to maintaining and improving quality such as changes in intensity and new technology may not be considered.

The potential also exists for the Secretary of the Department of Health and Human Services actually to dictate practice standards of care for medicare beneficiaries by arbitrarily setting DRG rates at a level that fails to recognize changes and advances in medical practice.

The proposal fails to incorporate or allow for any appeals. To operate a prospective pricing system most efficiently, hospitals will require a sophisticated reporting and accounting system. As the proposal does not cover hospital outpatient services, will hospitals attempt to unbundle services by having services performed through their outpatient departments? Would hospitals have an incentive to bill separately for services previously performed on an inpatient basis and considered part of a normal course of treatment if those services are furnished in an outpatient setting prior to admission?

Finally, the proposal is planned for implementation without thorough testing and evaluation.

The American Hospital Association has also proposed a plan for prospective pricing under medicare for hospital services. The AMA has some of the same concerns about the AHA proposal as it does about the administration's. There is merit, however, in experimentation with the program, including the prospective pricing based on individual hospital experience.

This method for establishing base line price determinations can avoid the problems arising from use of nationally applied DRGs. We are concerned, however, that the AHA plan would create serious inequities and disparities among hospitals and beneficiaries. The plan has the potential for creating a two-class hospital system with disruption in the patient-physician relationships.

We are also concerned with the proposal to reimburse outpatient departments on a charge basis, using the hospital cost of providing such a service as a basis for reasonable charges. This proposal would not create an incentive for use of the least costly appropriate setting for furnishing outpatient services.

Mr. Chairman, the American Medical Association endorses experimentation with prospective pricing methods. We recommend that this committee reject the administration proposal to impose an untried system across the Nation. The American Medical Association recommends that this committee authorize the administration's proposals and other prospective pricing proposals to be demonstrated on a limited scale in various States. Analyses of these proposals of present demonstration projects and the New Jersey program will help in assessing the feasibility of implementing a new nationwide system for hospital reimbursement.

In recommending the continuation of ongoing demonstration projects and institution of new demonstration projects for prospective pricing for hospital services, we realize that the immediately sought goal of program savings may not be fully achieved. In calling for further demonstrations on prospective pricing, we realize that many hospitals could suffer adverse effects if the section 223 limits now in place are allowed to rachet down over the next 2 years. As tightening of the section 223 limits could adversely effect the quality of care available, we recommend that the Congress either repeal the provision of TEFRA that would lower the section 223 limits from 120 percent of the means to 110 percent of the means, or delay the scheduled timetable for reaching the 110 percent level.

We also recommend that during this period the target rate incentive remain in place, and that it be modified to allow ajustments and waivers necessary to meet the unique circumstances that hospitals in various regions or various categories might face.

While these program changes would not result in the same level of cost savings projected in TEFRA, the section 223 limits would still apply to all inpatient hospital services, and the incentive target rates for determining maximum allowable operating costs would continue to be in place.

The American Medical Association recognizes the tremendous task that is before you. On one hand is the huge budget deficit and the compelling need to find means by which to reduce the deficit. On the other hand, it is your responsibility to maintain the quality of care available to the American people.

The AMA is opposed to the rationing of needed medical care for cost containment purposes. We are equally opposed to restricting access to advances in technology that can be demonstrated to save lives, alleviate suffering, prevent disability and enhance the quality of life. A radical restructuring of the payment methodologies for hospital care could cause these negative results.

Mr. Chairman, the administration's proposal has no track record. No appropriate experiments have been undertaken. There are no assurances that it will be effective, and it creates the significant possibility of providing windfalls to some hospitals, and diminishing the quality of health care available to medicare beneficiaries as the program progresses. Continuing demonstration projects and thorough analysis can lead to the development of a responsible and effective prospective pricing methodology. While this may not immediately reach the desired cost savings, it will not place the medicare beneficiaries at risk of facing a loss of quality of medical care.

Mr. Chairman, I thank you very much for the opportunity to be here, and I would be pleased to respond to any questions.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Dr. Schenken follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
United States Senate

RE: Prospective Pricing for Hospital Services under Medicare

Presented by
Jerald R. Schenken, M.D.

February 17, 1983

Mr. Chairman and Members of the Subcommittee:

My name is Jerald R. Schenken, M.D. I am a physician in the practice of Pathology in Omaha, Nebraska, and I am Vice Chairman of AMA's Council on Legislation. With me is Ross N. Rubin, Director of AMA's Department of Federal Legislation. The American Medical Association is pleased to have this opportunity to testify on the issue of prospective pricing for hospital services furnished to Medicare beneficiaries.

Mr. Chairman, the American Medical Association fully recognizes that today's hearings to discuss a new methodology for determining payment for hospital services is taking place not only because of rising costs but because of severe economic pressures and a rapidly growing federal deficit. I think it is safe to say that given increased economic growth, lower unemployment and higher federal revenues, the pressure would not be as great to restructure hospital reimbursement so radically. The radical nature of the proposed restructuring cannot be stressed too strongly because the changes proposed will have a long-term effect on health care delivery beyond the Medicare program.

There is no doubt that the American people now spend a very significant amount on health care services. This is because the Medicare program was created in 1965 as a vehicle to increase resources devoted to health care for the elderly by improving access to high quality care. The program has been a tremendous success in providing health care services which are unparalleled anywhere in the world. However, the economic problems facing this country are real, and you are faced with many difficult choices. In order to look at rising hospital costs under Medicare, Congress mandated the Secretary of the Department of Health and Human Services (HHS) to develop for presentation to the 98th Congress a proposal for prospective pricing for hospital services.

In appearing before you to discuss the proposal presented by the Secretary, we ask that you keep two thoughts in mind:

(1) the principal purpose of prospective pricing is not to improve access to or the quality of health care in the United States; and

(2) the Administration's proposal, slated for implementation on a nationwide scale by October 1, 1983, has never been tried, even on a limited scale.

While the American Medical Association is concerned about the increase in hospital costs, we are also concerned about the quality of care that would be available to Medicare beneficiaries under the extreme modifications proposed. Short-term budgetary solutions that do not assure continued availability of quality health care should not be viewed as viable alternatives if the program goal is to maintain a single system of health care that offers all Medicare beneficiaries access to quality health care.

The American Medical Association supports the development and exploration of systems for payment to institutions on the basis of predetermined rates or other payment systems that create incentives for facilities to be more cost-conscious. The American Medical Association has recognized the need to consider alternative forms of hospital reimbursement. In early 1978 the AMA adopted a recommendation of the National Commission on the Cost of Medical Care calling for the exploration of systems for payment to institutions on the basis of predetermined rates or other payment systems that create incentives for facilities to be more cost conscious. In accepting this recommendation, we pointed out that such systems should be implemented on a broad scale only if they prove to be effective. It would be inappropriate to institute a radical change in the Medicare hospital reimbursement system without assurances that quality care will be maintained. To this end, we strongly caution against the implementation of any full-scale prospective pricing system without experimentation and until ongoing projects have been analyzed to determine their effects on costs and quality.

DEMONSTRATION PROJECTS

"Prospective reimbursement" experiments have now extended over a period of some ten years, and the prospective systems have been both criticized and extolled over the years. Depending upon the forum, these characterizations have varied in degree. What has become apparent, however, is the lack of adequate analysis of the various "experiments" that have gone on to date. Moreover, studies of the various state systems with prospectively determined payments have examined only the question of possible program savings; they have not examined the impact of the payment methodology on the quality of care.

For example, an analysis of the hospital payment programs in the states of Arizona, Connecticut, Indiana, Kentucky, Maryland, Massachusetts, Minnesota, New Jersey, New York, Rhode Island, and Washington in the Winter 1981 issue of Health Care Financing Review (a publication of HHS) points to varying levels of savings generated in each of these states. However, this very study also points to a most significant flaw in the research to date on prospective pricing: the research fails to answer the important questions concerning how the reimbursement mechanism has affected the quality of care available. The study concluded with the following statement:

> We have examined only part of the evidence that deals with the effects of prospective reimbursement programs, and the results we presented in this paper are preliminary. In later phases of the national hospital rate-setting study, better data will be available for analysis, and we will undertake a much more comprehensive examination of program effects. Until an analysis has been made of the effects of prospective reimbursement programs on the quality of care, on the accessibility of hospital services, and on the financial viability of hospitals, the information necessary for sound policy decisions is not complete. (Emphasis added.)

It is thus clear from this statement that the HCFA study is still ongoing even as to costs. In addition to the fact that the existing demonstration projects and studies have failed to measure changes in quality, recent statistics raise questions about the ability of prospective pricing systems to maintain program savings. As reported in the

April 16, 1982, issue of Hospitals, the percentile change of annual hospital expenditures per capita has shrunk from a 4.3 point spread in 1978 between states with mandatory rate controls and other states to a mere 0.1 point spread in 1980 in favor of states with mandatory controls.

While prospective pricing programs in various states appear to have had some success in holding down the rate of increases in the cost of hospital care in comparison overall with states without prospective pricing, this one factor does not tell the whole story. In reality, states that have already imposed rate-setting schemes did so largely because of unacceptable costs experienced within those states. Those states, therefore, had high costs built into their prospective systems. By way of illustration, per capita hospital expenditures for states with mandatory programs was $250 in 1976 versus $196 for all other states. In 1980 the mandatory states had a rate of $373 compared to $329 for the other states.To compare only the rate of increases in mandatory states with those in other states is inappropriate. Yet this has been the primary measurement.

In addition to these concerns, recent statements from the Department of Health and Human Services indicate a puzzling lack of consistency of view on prospective pricing systems. As noted above, HCFA on the one hand has stated a need to examine further these programs to ascertain their effect on costs and on the quality of care. On the other hand, Secretary Schweiker on October 8, 1982, published a notice in the Federal Register expressing his view that no more demonstrations are needed except for prospective pricing systems with reimbursement based on Diagnosis Related Groups (DRGs).

Mr. Chairman, from these seemingly contradictory statements it is apparent that none of these former projects would be viable for nationwide implementation at this time. Instead, it appears that HHS has proposed a new system — the only system, however, that by its own admission needs further demonstration.

It should be noted that states with mandatory review programs have not all experienced satisfactory results. Massachusetts, one of the early rate-setting states, has now been forced to create a new system because the costs were too high. A rate review system was totally scrapped in Colorado. Illinois, after preliminary development, also scrapped its program. After the implementation of strict rate-setting in New York, a rash of hospital bankruptcies and closures has taken place as hospitals exhaust endowment funds, defer bill paying and take other drastic measures. As a result of operation of the New York system for over a decade, 81% of that state's hospitals were operating at a loss in 1980. The combined operating losses for that year totalled $256 million compared to a combined surplus of $16 million for the remaining hospitals. Conditions in New York City deteriorated to the point that the federal government had to step in to bail out failing hospitals that served large inner-city populations.

THE ADMINISTRATION'S PROSPECTIVE PRICING PROPOSAL

The Administration has not presented its proposal for prospective pricing for hospital services in legislative form. These comments are based upon the report to Congress by the Secretary of HHS in response to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), P.L. 97-248.

Rate Setting and Payment

Under this proposal, prospective rates for inpatient hospital services to Medicare beneficiaries will be set in advance and fixed for all inpatient services on an annual basis. These rates will serve as payment in full for inpatient hospital services, with program beneficiaries being responsible for only statutorily-set deductible and coinsurance amounts. When hospitals receive a payment that is greater than the costs of treating Medicare beneficiaries, they will keep that "bonus," and they will be at risk where treatment costs are greater than the payment rates. Payment amounts would be updated annually.

Payment will be on a per-discharge basis. The initial year payment figure will be determined by a formula where base year costs are established for all hospitals "on a national representative Medicare cost per discharge." This will establish a single national representative cost per discharge. The report from the Secretary fails to state at what level this "representative" cost will be set. To recognize hospital case mixes, actual payment rates will be determined by adjusting the national cost-per-discharge rate by a factor assigned to each of 467 Diagnosis Related Groups (DRG). For example, if the national discharge rate is $3,000, and the DRG intensity factor for the diagnosis is 3, then the hospital's Medicare reimbursement will be $9,000. This will therefore create 467 national reimbursement rates. Adjustments will be allowed only for regional variations in labor-related costs.

Excluded Costs

Capital costs and direct costs of medical education will continue to be separately reimbursed on a reasonable cost basis, and outpatient department costs will be calculated separately from the DRG system. Indirect educational expenses (expenses related to additional tests and the particular types of patients attracted to teaching hospitals) will be reimbursed to the hospital on a lump-sum basis.

DRG Classifications

The DRG classification system will be the 1981 methodology developed at Yale University. This system groups patients into 467 categories derived from 1.4 million discharge records. Additional payments above the DRG rate will be authorized for extremely long-stay cases based upon "outlier" "trim points." Trim points will be determined by a review of patient stay data.

Exceptions

The proposal will not cover hospital services for those health maintenance organizations operating on a risk basis. In situations where a community is served by a sole hospital provider, the Secretary will be authorized to make appropriate exceptions and adjustment to the DRG rates for these hospitals. Payment amounts, exceptions, adjustments, and rules to implement the system would not be subject to any form of judicial review. Psychiatric, pediatric, long-term stay hospitals, and skilled nursing facilities would not be covered by the proposal.

SPECIFIC CONCERNS OVER THE ADMINISTRATION'S PROPOSAL

Mr. Chairman, we have numerous concerns about the Administration's proposal. Without question, a system can be devised to achieve any targeted level of cost savings over the existing system. The General Accounting Office pointed this possibility out in a letter report to Senator Packwood on May 10, 1982 (No. HRD-82-73). This report stated:

> A prospective system can be designed to achieve almost any level of program savings desired by selecting the appropriate set of rules. However, there is a point when a reduction in reimbursement could adversely affect access to and/or quality of care for beneficiaries. Also, if the prospective reimbursement does not apply to all payors, a facility can have an incentive to shift costs to non-covered payors.

We agree with the GAO's conclusion that any proposal, including the Administration's, could reach that point where there will be an adverse effect on access to and on quality of care for Medicare beneficiaries. From our review of the Administration's proposal, a number of readily apparent problems relating to quality of care are raised:

- The proposal fails to specify the methodology for the establishment of the national uniform rate. What is to assure that this rate will be adequate? Will this rate be arbitrarily established based on a predetermined cost savings figure?
- The proposal, unlike the New Jersey program, fails to recognize legitimate variances in different institutions. This could result in situations where individual hospitals will have to operate at the lowest common denominator.
- The proposal's use of DRGs as the case-mix adjuster fails to recognize variations in the intensity of illness and the impact of complications within each DRG and the variations in services needed to address these cases. While the proposal recognizes "outlier" cases, it does not contain any explanation of the methodology for determining outlier cases, and it does not discuss the level of reimbursement for such cases.

- The proposal would provide windfall reimbursement levels to some hospitals by providing them with reimbursement above the costs of providing services while causing substantial disruption of services in those hospitals whose actual costs are above the national average.
- While the proposal does call for annual updates for DRG reimbursement, factors pertinent to the provision of care and central to maintaining and improving quality such as changes in intensity and new technology may not be considered. The potential also exists for the Secretary of HHS actually to dictate practice standards of care for Medicare beneficiaries by arbitrarily setting DRG rates at a level that fails to recognize changes and advances in medical practice. By way of example, we wonder whether the Secretary would alter the DRG payment in a situation where a new care regimen is developed that may better meet the needs of the individual patient but may be more expensive than the previous regimen of care.
- The proposal fails to incorporate or allow for any appeals. We must question what recourse hospitals will have if DRG rates prove inadequate to meet their actual needs.
- To operate a prospective pricing system most efficiently, hospitals will require a sophisticated reporting and accounting system. Will small hospitals be at a disadvantage? Will start-up money be authorized to develop techniques needed to manage the system?

- As the proposal does not cover hospital outpatient services, will hospitals attempt to "unbundle" services by having services performed through their outpatient departments? Would hospitals have an incentive to bill separately for services previously performed on an inpatient basis and considered part of the normal course of treatment if those services are furnished in the outpatient setting prior to admission?
- The proposal is planned for implementation without thorough testing and evaluation.

AHA PROPOSAL

The American Hospital Association (AHA) has also proposed a plan for prospective pricing under Medicare for hospital services. It has many features similar to the Administration's proposal, including a fixed cost per discharge and case weighting based on the use of DRGs. However, there are major differences that include the use of each hospital's cost base for establishing the reimbursement rate, the ability of hospitals to bill patients for charges not covered by Medicare in addition to Medicare mandated copayments and deductibles, and coverage of the hospital's outpatient department under a usual, customary and reasonable charge basis using each hospital's outpatient department costs as the basis for charges.

The AMA has some of the same concerns about the AHA proposal as it has about the Administration's. There is merit, however, in experimentation with the proposal, including the prospective pricing based on individual hospital experience. This method for establishing base-line price determinations could avoid the problems arising from use of nationally applied DRGs. We are concerned that the AHA plan would create serious inequities and disparities among hospitals and beneficiaries. The plan has the potential for creating a two class hospital system, with disruption in the physician-patient relationships.

We are also concerned with the proposal to reimburse outpatient departments on a charge basis using the hospital cost of providing such a service as the basis for reasonable charges. This proposal would not create an incentive for use of the least costly appropriate setting for furnishing outpatient services. The Omnibus Budget Reconciliation Act of 1981 called for similarity of payment for similar services furnished in hospital outpatient departments and physicians' offices.

THE NEW JERSEY SYSTEM

We realize that some will point to the New Jersey hospital payment experiment and indicate that this is adequate proof that the health care system in this nation will not be harmed by a system of prospective pricing based on a DRG concept. However, we must point out that the system in place in New Jersey is just now being fully implemented and starting to be evaluated. Furthermore, regardless of the outcome of the analysis of the New Jersey program, it is important to realize that this system is very different from the Administration's proposal. First of all, the New Jersey system covers all payors, with all payors being responsible for approximately equal payments for similar services. In addition, the New Jersey system was implemented in a state that does not have a single small hospital with a bed population under 100. The New

Jersey system also has other significant differences between it and the Administration's proposal. By way of example, the New Jersey system is based on a statutory commitment to cover all reasonable hospital costs, and the New Jersey system recognizes and allows for increased hospital compensation if the initial DRG rate determination provides inadequate revenue. To date, not a single hospital has accepted the initial DRG determinations as final payment for services. The Administration's proposal, on the other hand, sets a fixed price with no basis for appeals and is not concerned about the financial viability of the nation's hospitals.

The "Overview" of a study being conducted by the Health Research and Educational Trust of New Jersey indicates that "there is considerable uncertainty regarding the system's ability to contain costs." While this study is just in its initial stages, as is the New Jersey reimbursement system itself, it hopes eventually to answer the following questions:

- Is the system properly designed and does it work as anticipated?
- Does the system make a difference in terms of the hospitals' overall performance, effectiveness, and efficiency in providing medical care?
- What is the system's potential as a regulatory device, management information or data-based planning mechanism, and utilization review tool?
- What are the advantages and disadvantages associated with DRG reimbursement for hospitals, third-party payors, and others?

We note that the Congressional Budget Office is now conducting a detailed study of the Administration's proposal and that any actions should await the release of CBO's report.

We are concerned that the Administration's proposal would create an inadequate reimbursement system that would foster a two-tiered system of health care in this country, with one level of care for private-pay patients and a lower level of care for Medicare patients. The proposal contemplates that Medicare will not bear its fair share of financial responsibility for indigent patients, and the potential would exist for some hospitals to discourage acceptance of such patients. Such a payment system will place hospitals with large indigent patient loads in a situation where they will find it increasingly difficult to stay open.

Given the fact that the Administration's proposal is dissimilar from any of the ongoing demonstration projects and even from the New Jersey program, we believe it would be highly imprudent to go forward and implement a totally new national system of prospective pricing for all in-hospital care furnished to Medicare beneficiaries.

RECOMMENDATION OF THE AMA

Mr. Chairman, the American Medical Association recognizes that the rationale behind moving toward prospective pricing for hospital services is to reverse incentives that fail to encourage hospitals to deliver care in the most efficient manner possible. As previously stated, the American Medical Association endorses experimentation with prospective pricing methods. However, we firmly believe that such methods should not be implemented on a broad scale unless they prove to be effective. We urge you to consider this reasoned approach, and we recommend that this Committee reject the Administration's proposal to impose an untried system across the nation.

It is important to remember that decisions made in the near future concerning how hospitals and other providers under the Medicare program are reimbursed will have long-range implications on access to and the quality of care for years to come. We fully expect that hospitals, through their boards, administrators, and medical staffs, will all respond to changes in the reimbursement system in order to try to maintain access to and quality of care. In our view, if a system under Medicare and Medicaid under-reimburses hospitals, we can expect adaptations to such under-reimbursement by shifting costs to other payors, deferring costs such as maintenance (often leading to higher long-term costs), reducing nursing and other essential patient care staff, and postponing or eliminating necessary modernization and technological improvements (depriving patients of the highest quality of care). In extreme cases hospitals providing essential care could be forced to close.

Complex problems and complex systems should not be addressed with untried solutions. The American Medical Association recommends that this Committee authorize the Administration's proposal and other prospective pricing proposals to be demonstrated on a limited scale in various states. Analyses of these proposals, as tested, the present demonstration projects, and the New Jersey program will help in assessing the feasibility of implementing a new nationwide system for hospital reimbursement.

In recommending the continuation of ongoing demonstration projects and instituting new demonstration projects for prospective pricing for hospital services, we realize that the immediately sought goal of program savings may not be fully achieved. However, considering that the

Medicare program is one designed to provide health care to millions of American people, we feel it appropriate that the quality of that care be placed ahead of potential dollars to be saved. In calling for further demonstrations on prospective pricing, we realize that many hospitals could suffer adverse effects if the Section 223 limits now in place are allowed to be ratcheted-down over the next two years. As tightening of the Section 223 limits over the next two years could also adversely affect the quality of care available, we recommend that the Congress either repeal the provision of TEFRA that would lower the Section 223 limits from 120% of the mean to 110% of the mean or delay the scheduled timetable for reaching the 110% level. We also recommend that during this period the "target rate" incentive remain in place, and that it be modified to allow adjustments and waivers necessary to meet the unique circumstances that hospitals in various regions or categories face.

While these program changes would not result in the same level of cost savings projected in TEFRA, the Section 223 limits would still apply to all inpatient hospital services, and the incentive target rates for determining maximum allowable operating costs would continue to be in place.

CONCLUSION

The American Medical Association recognizes the tremendous task that is before you. On one hand is the huge budget deficit and the compelling need to find means by which to reduce that deficit. On the other hand is your responsibility to maintain the quality of care available to the American people. The AMA is opposed to the rationing of needed medical care for cost containment purposes; and we are equally opposed to restricting access to advances in technology that can be demonstrated to save lives, alleviate suffering, prevent disability and enhance the quality of life. A radical restructuring of payment methodologies for hospital care could cause these negative results.

Mr. Chairman, the Administration's proposal has no track record. No experiments have been undertaken. There are no assurances that it will be effective, and it creates the significant possibility of providing windfalls to some hospitals and diminishing the quality of health care available to Medicare beneficiaries as the program progresses.

I point out the above to stress that with the validity of the Administration's prospective pricing as an appropriate nationwide reimbursement system so seriously in question, the nation cannot afford the risks involved. We strongly urge that further demonstrations go forward before any attempt is made to alter so radically the manner in which payment is made for hospital care.

We urge you to consider carefully the questions raised in this testimony in your consideration of prospective pricing proposals. Continued demonstration projects and thorough analysis can lead to the development of a responsible and effective prospective pricing methodology. While this may not immediately reach the desired cost savings, it will not place Medicare beneficiaries at risk of facing a loss of quality medical care. A moderate, reasoned approach in the development of a new payment methodology for the future that will create incentives toward cost savings could have the desired effect of preserving the quality of care that has been promised to Medicare beneficiaries, while concurrently resulting in effective cost savings.

I will be pleased to respond to any questions the Committee may have.

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Senator **Durenberger**. I am going to ask the chairman of the committee, who has to be at another committee meeting simultaneously, to take the first round of questions.

Senator **Dole**. I don't want to interrupt the panel, but we have Rules Committee hearings on our budget, so if we don't have any money, we can't meet, which would probably be all right with everybody here.

The last time the AMA testified before this committee I indicated our desire to begin a reexamination of medicare reimbursement, physician reimbursement in particular. At that hearing we were told that you were going to get busy on that and have us some recommendations on physician reimbursement. Is anything happening in that area?

Dr. **Schenken**. The AMA has embarked on an aggressive program to develop a national health agenda, and it is in the final stages. But we do not yet have from that particular program specific recommendations. We still have a variety of outstanding recommendations from before, including the ones today which we think will help bridge the gap.

Senator **Dole**. Our problem is that medicare is going to sink one of these days if everybody comes up here and tells us not to do anything this year, do it next year, or don't do it at all. If we think social security is in trouble, we ought to take a look at the medicare trust funds in the next 4 or 5 years. We have a very heavy responsibility on this committee to try to somehow get a handle on health care costs. They are about to eat us up. And we would hope that those who are directly involved would do more than suggest that we delay it for another year. We can't delay it for many more years. We won't be around—medicare won't be around.

At the same time we are also concerned that we don't shuffle off mental health priorities in the process, as I indicated in the speech I made to that group in Florida recently.

I have a number of questions for when I come back. But I know we are going to be asking about budget resolutions to address health care costs. I assume that we will act responsibly in this committee as we have tried to do in the past, but we really need help from the people who are out there providing the care. I don't say you are doing anything wrong, but we have got to restrain the growth of health care costs. Inflation is going down, while the health care cost index is going up.

A lot of us went along with the voluntary effort. We were persuaded by the AHA the AMA and others that that was the best way to go, but the costs kept going up. We helped fight off cost containment, mandatory cost containment. We are always told they are going to suggest something next year. I think it's about time that we do it.

Dr. **Schenken**. Mr. Chairman, I think it would be fair to say that the American Medical Association would agree with you. And I think we have as much a concern as the committee about the integrity of the program, and the care of the people. And, quite frankly, while we are not totally happy with it, we feel reasonably pleased that the rate of increase in physicians' fees over the last 5 years have been less than those for all services. But I don't think that takes away from your obligation or ours. And we would agree with that.

However, we do feel that representing physicians and patients in front of you, we are also obligated to advise you to the best of our ability as to what we think the impact of these proposals could be on quality. And, therefore, I think it gets down to we have to work together on this program, and we are willing to do what we can.

Senator **Dole**. I don't quarrel with that. I just say that the fuse is getting fairly short. And if we are going to work together, we ought to start working together. I mean we ought to do it this year instead of saying, well, let's put it off and let's have some experiments for 1 year or 2 years or 5 years. That's only my view. It may not be shared by others on the committee, but I know the Budget Committee is looking at medicare. It's a big, fat target out there like the defense budget. In a different way, it's big so it is easy to notice. And they are going to say "Why aren't you doing more on medicare?"

We did quite a bit in 1982, as you know, on TEFRA. We are still hearing from pathologists—one offered me a free autopsy. [Laughter.]

Senator **Durenberger**. You had better go to Rules.

Dr. **Schenken**. I wasn't one of them, sir.

STATEMENT OF DR. FRANK J. PRIMICH, MEDICAL SOCIETY OF NEW JERSEY, LAWRENCEVILLE, N.J.

Dr. **Primich**. I am Doctor Primich from New Jersey. And I am representing the Medical Society of New Jersey.

Senator **Durenberger**. Right.

Dr. **Primich**. The question was asked, which was an excellent question primarily because of my own inability to properly express—it got lost in the shuffle. And I have prepared an answer to it. The question was, Why have health care costs escalated at a greater rate than other general costs? And what, if anything, could we do about it?

And if you would just bear with me a moment, I would like to give you my reasons and my proposed solutions.

Senator **Durenberger**. About how long might it take? That's an enormous question.

Dr. **Primich**. I know. This, again, does not address all the factors, but just some of the major ones.

Senator **Durenberger**. All right.

Dr. **Primich**. The first one is the high cost of compliance with government overregulation. The solution here, I feel, would be deregulation or at least minimizing additional regulations such as DRGs.

The second point is excessive demand for service when it is perceived as free. And the solution here is already in the works in this concept of deductibles and copayment. Not only for medicare, but I think this program should be advanced for all insurers, private and otherwise, because one of the major reasons for this escalation, of course, is first dollar coverage wherein the patient demands the coverage that they have paid for. And a physician is in a very difficult position to deny this, which brings us to the third item. And that is the cost of essentially unnecessary services to defend against costly litigation.

And the solution here goes in a different direction. A realistic judicial restructuring of current malpractice criteria. Because in the case where we do not do all these exorbitant things like CAT scans for sinus headaches, if that patient turns out to be that one in a million who has a brain tumor, we, the hospital, will be sued for $1 million. And particularly under the structure as it stands now, since it will be paid for by the third party payer, the patient thinks it is a wonderful thing that they had this technique used upon them.

The fourth is that there was a continuing catch-up of salaries to traditionally underpaid hospital workers. And as far as a solution, recent increases, which are reflected in these numbers that we are hearing, have stabilized this situation. And the projection right now for those who have been studying it is that hospital personnel salaries will not increase by anything more than the common denominator or whatever it is in the rest of the economic field.

Senator **Durenberger**. I thought you were against regulation.

Dr. **Primich**. I am, sir.

Senator **Durenberger**. All right.

Dr. **Primich**. I said stabilized. I said nothing about regulating it. This has caught up. And as I said, it will not, right now—it is debatable as to what portion of that excess increase that is represented, but it was a factor, which we now at least for the reasonable future will not have to contend with.

The fifth one is major technological advances. This means high cost equipment and high operational costs. And the solution here is a very difficult decision. We either pay the cost or declare a moratorium on progress. And that's the tough decision that you gentlemen are going to be forced to make—what direction we go on that.

The last one is waste inefficiency, assorted rip-offs, such as willful cost inflation. And this is among the minor things. A relative small component, as far as I am concerned, already being addressed by peer review on a voluntary and mandatory basis. If patients had a greater financial responsibility and cost consciousness, the free market control system would get a fairer opportunity to operate. This would be more effective, and certainly less burdensome or costly than further regulations.

Thank you.

Senator **Durenberger**. Thank you very much.

[The prepared statement of Dr. Primich follows:]

Frank John Primich, M.D.
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Mr. Chairman, members of the Committee, interested parties, innocent bystanders;

My name is Frank J. Primich, M.D. I have been a practicing physician in New Jersey for over thirty years. Throughout that time I have firmly believed that it was my responsibility to my patients, not merely to diagnose and prescribe, but to protect them against external forces which would adversely effect their health and welfare.

I am testifying formally on behalf of the Association of American Physicians and Surgeons, a national organization dedicated to the preservation of the patient-doctor relationship of private fee-for-service practice, and resistance to intrusion into that relationship by any third parties, particularly government. Formally, I am also representing the Medical Society of New Jersey, the oldest state medical society in the nation.

If these hearings follow the format of comparable state-level hearings in New Jersey, the preponderance of testimony will be submitted by those who see themselves as "winners" in this issue. I beg your indulgence, to permit me to also speak, as one of them, for the certain "losers"; the over 2,000,000 New Jersey Blue Cross subscribers, the even higher number of New Jersey tax-payers, and the more than seven million potential patients in my state.

I would like to acquaint you with the New Jersey "experience". Note that I do not refer to it as an "experiment", the commonly heard misnomer. What has been perpetrated in New Jersey meets none of the moral, ethical, nor scientific criteria of an experiment. As is so often the case, a well-intentioned piece of legislation has been distorted in its bureaucratic implementation to the point where the results are worse than the original problem.

In evaluating some of the other testimony you will hear, particularly statistical material, you should be reminded that prior to the institution of the present New Jersey program, our state was already among the most over-regulated regarding hospital rates.

New Jersey Public Law, 1978, Chapter 83 proposed to resolve the perceived inequity in hospital costs to the various catagories of bill payors, and to further resolve the "uncompensated cost component" of hospital billing; over $100,000,000 annually.

Diagnosis Related Groupings (DRGs) were seen as a bizarre disruptive innovation with only one "valid" favorable aspect. Federal regulations would not permit the necessary alterations in Medicare and Medicaid rates, except in conjunction with an innovative "experiment". At that point in time the term was certainly applicable. Its sponsors convinced the Health Care Financing Agency that their methodology would:

1. facilitate the rate-setting process
2. accomplish cost containment
3. improve quality of care, and upgrade physician performance
4. demonstrate the value and validity of "prospective payment"
5. correct the pre-existing "cost shift" inequities

DRGs HAVE NOT, AND CANNOT, ACCOMPLISH ANY OF THE ABOVE!

DRGs were introduced in New Jersey as a voluntary limited experiment. As such, despite misgiving regarding the outcome, MSNJ gave CONDITIONAL APPROVAL to the program. VOLUNTARY was the first word to go. The program started in 1980 with 26 hospitals. Only ten volunteered, so sixteen others were "selected" to give the "necessary case-mix". LIMITED didn't last much longer. Before the initial group was even organized, it was announced that an additional 40 hospitals would be added to the program in 1981, with all the rest scheduled for 1982 entry. EXPERIMENT, is the term which best illustrates the insincerity of the bureaucrats. An experiment, of any type, must be evaluated by the results, before claims can be made of success. The New Jersey program was expanded statewide without any evaluation. It is now being projected nationally as a successful model to follow. Its only success, to date, is that the people haven't risen up in rebellion. They can thank the press and media which mindlessly pass along the false optimistic claims of the Department of Health.

The Health Research & Education Trust (HRET), the supposedly impartial evaluation organization, currently rates the available information as INCONCLUSIVE! This is a group composed of and supported by those whom I contend fancy themselves as among the "winners". There is no representative of those who pay healthcare insurance premiums, nor those who pay their own bills. There is no representative of patients who will be subjected to sub-standard care and de facto rationing. There is no true representation of practicing physicians who saw, now see, or will eventually see the devastating effects this abysmally impersonal approach to hospital care fosters.

To any individual who prides himself in being open-minded, it is frustrating to hear repeatedly, from supposedly authoritative sources, that the DRGs have good and bad features. This implies that final judgement of their merits must await some retrospective evaluation in the distant future, hopefully, beyond the statute of limitations which might hold those responsible who initiated this stepping-stone on the road to Socialized Medicine. The non-judgemental approach implies a balance between good and evil. When the good accrues to relatively few, and the damage is spread over all the rest, the scales of justice tip precipitously. In a Socialistic or Totalitarian society such actions are commonplace. If they are tolerated here, our other cherished liberties shall be further endangered.

Let us first look at the supposed good features. No one can deny that it is a boon to the computer industry. It would appear to help alleviate the unemployment problem, since more people become necessary in the business offices of hospitals, not to mention the bureaucrats needed to play out the charade. It offers the statisticians on both sides of the discussion an almost infinite supply of numbers to play with, so varied and abstract as to permit any conclusions imaginable. It should absolutely identify those providers who grossly overutilize hospital facilities. It is hoped to have an educational impact upon those physicians who practice bad medicine. It is projected as the only regulatory vehicle which meets the bizarre requirements for the Medicare-Medicaid waver, without which N.J.P.L.,1978, c.83 would be doomed. It, therefor, would permit the equalization of hospital billing intended by the Legislature, and eliminate "cost shifting". It is one approach to assuring survival of inner-city hospitals and those institutions whose inept management has placed them in jeopardy.

Now, let's examine these suppositions in reverse order:

Subsidization of ineptitude can only lead to its perpetuation.

Inner-city hospitals have arrived at their deplorable state, in large part, because of the false promise of high quality care for all, projected by politicians who had little appreciation or concern for the ultimate cost. To bail them out by increasing taxes would be very unpopular and politically hazardous.

Cost shifting, the problem supposedly addressed by N.J.P.L.,1978, C.83, turns out to be replaced by a more onerous cost shift.

Discounted rates for Blue Cross, Medicare, and Medicaid had made it necessary for hospitals to raise their rates to commercial insurers and self-pay patients in order to break even. Though the theory overlooks some significant factors, it would seem fair that all payors pay the same amount for the same service. This loses its element of fairness when the factor of the annual $100,000,000 plus in uncompensated costs is brought into the equation. These costs, which Big Brother had benevalently proposed to underwrite, were to now be pro-rated among the various payors.

Blue Cross, with over 2,000,000 subscribers in New Jersey, has been forced to raise its premiums in 1982 by over 40%, with the threat of more to come. The taxpayer is being "Spared" by paying out of his other pocket as a health insurance subscriber. This is not merely a "cost shift". It turns out to be a "blame shift" as well. The hostility of the victims of this shell game is focused upon the insurance companies and the healthcare providers who are charging such "unconscionable fees".

This same scenario applies to all other "prospective payment" proposals, not just DRGs.

The Medicare-Medicaid waver deserves condemnation in passing. It permits the Federal government to pay "a little more" than prior rates, but stipulates that if costs are higher than under the old system, the hospitals will be responsible for return of the difference. There is no such protection available to insurance subcribers or self-payors. Preliminary reports show most New Jersey hospitals exceeding their Medicare caps. They have been told not to worry. If the Federal government doesn't press Poland and Mexico regarding their indebtedness, why would it pick on our own hospitals? I tried that logic with the IRS, and it didn't work!

Gross overutilizers and bad practitioners are well known and easily recognized in any institution. Fortunately, they are few in number. If there were a genuine desire to weed them out, there are far simpler ways of doing it than mandating "cook-book" medicine for all physicians and patients.

Increased employment and computer utilization sounds facetious. Any humorous overtone fades when you realize that simple economy dictates that more clerical help be reflected in less employees directly involved in patient care. Computerization means that you, as an individual, will be converted to a number. Not even your Social Security number, if you are not exempt from that scam, but your DRG disease designation. Faced with the need for expert medical treatment, wouldn't you prefer the doctor of your choice, and the assurance that your care would be determined by his, or her, best judgement?

Since the primary concern of this Committee is the feasibility of prospective payment programs which might contain Medicare costs, let me dwell on that subject for a moment. New Jersey's current experience suggests that any paper savings regarding Medicare costs would require unmedical doctoring of the figures. In the event that such evidence is offered to you, I contend that any "saving" would be minuscule compared to the increased costs of regulation, conversion & compliance, and the already mentioned new "cost and blame shift". The average taxpayer can be deluded by references to his money, local money, state monev, and federal money. You are well aware of that shell game which diverts attention from the major issue. If we are to be concerned about the cost of healthcare, and we certainly should, it is the overall cost that must be addressed. Disrupting the entire healthcare system to achieve an unrealistic cosmetic effect would be a gross disservice to your constituents. Applying any of the proposed programs only to Medicare patients would be costly to everyone. Extending the process to all patients, an inevitable next step, in the name of cost containment would compound the travesty.

MSNJ fell into the early trap of trusting bureaucrats. We have recovered, and have a remarkable unanimity of agreement regarding the hazards of prospective rate-setting as practiced in New Jersey. We are desparately alerting the rest of the country.

The New Jersey Hospital Association originally opposed the program. It shifted to a position of neutrality because of inner conflict, and then chose to support DRGs with the misguided delusion that they would have better bargaining power. It has taken a few years to show their folly, and will take a few more before they admit their error. Initial allowances, the carrot, were fairly reasonable. Loopholes abounded, and most hospitals showed a "profit". Then came the stick. Tightened rates and coersive threats regarding appeals changed the picture drasticly. One hospital showed a profit of $3 million in 1981, broke even in '82, and projects a loss for '83. Another made over two million in '81, lost a little in '82, and is concerned about insolvency in '83. These are not exceptions. They are the rule. Jersey City Medical Center, which was to have been one of the major beneficiaries of the program declared bankruptsy. The courts have declared them ineligible for that escape route, but none the less the hospital is broke. There will undoubtedly be a bailout, not surprisingly at the taxpayers expense.

The appeals process was initially overwhelmed by largely justifiable complaints. Even cursary attention to those complaints rendered the whole concept of prospective payment inoperable. Final reconciliation for the original 26 hospitals which entered the program in 1980 were concluded for three in December of '82, bringing the total to six of twenty six at last count.

The quick fix for this problem is rather significant as to what can be expected. The 1983 proposed rates are accompanied by an offer of a 1% bonus if accepted. At a seminar attended by fiscal officers from most of New Jersey's hospital in November 1982, Jeff Warren of the rate-setting Commission informed the audience that the Commission was annoyed by appeals, would be inclined to reject most, and suggested that they grab the 1% bonus while they could. They were further told that if they chose to file appeals, the Commission reserved the right to withdraw the original rate package, and submit a new proposal, calculated by a different formula, which could be expected to average out to several percentage points lower than the initial offer. This highhanded attitude threatens to wipe out the appeal process, making the rate-setting process dictatorial, without recourse.

Lest anyone think that the 1% bonus should be adequate to correct any minor oversights, let me present the following case. Middlesex County Hospital entered the program in 1982. They appealed $9,000,000 in assorted items. At last count, the "unfriendly" rate-setters had approved $7,000,000, disapproved $500,000, and were still negotiating the remaining $1,500,000.

After hospitals had spent months calculating their 1983 budgets, the stringent 1983 proposed rates arrived. Since retrospective calculations showed the projected COLA type allowances for 1982 to have been in error (7%, rather than 9%), the 1983 rates were to be lowered by that 2% difference. The fact that 1982 and 1983 expenditures, particularly salary increases had been based on the Commission's erroneous estimate apparently doesn't matter. The hospitals are to be held accountable for the error. The silver lining to that cloud is that it should prove to those who need concrete evidence that central regulators are incapable of accurate projection.

In addition to my other duties I am President of the Medical Staff of Riverside General Hospital in the Hackensack Meadowlands. Riverside is the sole remaining proprietary hospital in New Jersey. The rate-setters refuse to permit any further allowance for return on investment. As a result this highly successful and highly respected institution will be forced to sell. So much for competition and Free Enterprise in New Jersey. Meanwhile, the altered calculations make it imperative that the 1983 budget be cut by $500,000. We are being asked to cut services to whatever degree is possible, think twice about potential cost-overrun admissions and discharge marginal cases early. Next year these pressures can be expected to be stronger. In other institutions, they already are. Orwell's 1984 comes next.

MSNJ has repeatedly requested in writing to be informed by the state Department of Health and the HRET evaluation team of any evidence that the quality of care has been improved. For obvious reasons, there has been no response.

I trust that you have been given copies of Volume 1 of the HRET DRG Evaluation. Despite my misgivings regarding the composition of the organization, their report is most enlightening, in a negative way. Don't be overwhelmed by its bulk. It can be catagorized best as underwhelming. 33 of the 80 pages are devoted to the bibliography. Most of the references are technical, theoretical, and questionable. 14 additional pages are tables which report on 3 serial surveys of participating hospitals. Failures of response and high "no opinion" percentages make the statistical validity suspect. My favorite is the question as to whether the DRG method of allocating costs is reasonable. 23 1981 entries into the system answered as follows: 30.4% Yes, 30.4% No, and 39.1% No Opinion! If that had been an election, "none of the above" would have won.

The double-spaced text is an easily readable 31 pages. The conclusions, half of page 31, are all that is really significant. As I have already noted, they are inconclusive. A vital question is raised as to whether the costs of compliance and implementation may not be greater than projected claims of cost savings. No mention is made of the regulatory costs. It is my belief that once total costs are computed, there will be a tremendous negative balance. As a cost containment program it is not cost- effective. The interminable wait for absolute confirmation of that fact will permit irreparable damage to the traditional concepts of healthcare financing.

State Senator Garrett Hagedorn best summerized the program when he asked a Department of Health witness, " Are you telling me that you want the health insurance subscribers to subsidize the costs of Welfare?" There was no denial.

Hospitals, in every catagory, are coming to realize that they will not be among the ultimate "winners", but they are still trying to make the best of a bad situation. Commercial insurers see the system as giving the a competative edge vis a vis Blue Cross, and Blue Cross is afraid to complain. Rates for both must continue to rise. The only real winners are the bureaucrats and the politicians. They continue to make a comfortable living, screwing up other people's lives.

I'll survive, because I'm tough. The hospitals will survive, because they must. The aged and the infirm are the biggest losers. They will succumb to what will be' referred to as fiscal euthanasia, but, unfortunately, it will be far from painless.

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Senator DURENBERGER. Dr. English.

STATEMENT OF DR. JOSEPH ENGLISH, M.D., CHAIRMAN, DEPARTMENT OF PSYCHIATRY, ST. VINCENT'S HOSPITAL AND MEDICAL CENTER, NEW YORK, ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. ENGLISH. Mr. Chairman, I am Dr. Joseph English, director of Psychiatry at St. Vincent's Hospital, which is a voluntary teaching hospital in New York City. We provide 60,000 inpatient days of care to psychiatric patients, and 100,000 outpatient visits a year. I am representing those patients and those physicians. For the 27,000 American psychiatrists, it is a pleasure to be here this morning to discuss with you this new prospective reimbursement proposal, and to identify with your previously expressed sentiments, and those recently expressed by Senator Dole, concerning the implications of this and other prospective reimbursement methodologies for the mentally ill.

We identify with your problem because if the medicare program goes broke, it is the psychiatric patient who is very often affected first in this kind of a fiscal dilemma.

So I want to say first of all that we support changes in reimbursement under medicare or any other system that is more efficient and more effective in providing incentives to hospitals to be more cost effective than the current system. I mean to give you one example of this that we have been concerned about for a long time. The fact that the medicare outpatient benefits for psychiatric patients is still limited to $250.00. It still is in 1983. Our estimate is that the current benefit in 1983 dollars is worth about $62.00. And I mean that is an enormous disincentive through the reimbursement system to more cost-effective care of the medicare patients. Now that is not precisely what you are discussing this morning, but we have been on record for better reimbursement and what I would like to do is raise with you just a couple of particular concerns relative to the present proposal before you that are specifically problems for psychiatric patients.

The first is the fact that the Secretary has exempted private psychiatric hospitals from this reimbursement approach. And we endorse that. And we commend the Secretary for that because he had a very good reason for exempting them. And that is the fact that he points out in his submission to you that this methodology has not been studied in private psychiatric hospitals. That the 14 DRGs that apply to psychiatric patients have not been tested there. We would welcome the opportunity to see that occur, but it has not. We welcome that exemption.

But our concern is that the 32,000 inpatient psychiatric beds in general hospitals, such as ours in New York, the largest provider of psychiatric services is included despite the fact that the study has not been done there or in private psychiatric hospitals or in general hospitals with scatter beds. And we feel that is an unfortunate problem, and we would appreciate an exemption there until those studies could be done. And we would welcome the opportunity to participate in that.

Second, we have concern about the impact of this approach on something like liaison psychiatry, which has begun to prove its cost effectiveness. For example, if patients in a general hospital for other reasons—for example, some studies that we want to submit with our formal testimony—that are there for hip fracture surgery, have the advantages of liaison and consultative psychiatry—studies indicate that the length of stay of those patients has been reduced from 42 days to 30 days compared to patients without those consultative services. That's a 28.6 percent reduction, and has enormous dollar implications. We are not sure how liaison psychiatry would be affected under this DRG methodology.

We also share concerns relevant to cost shifting. And I know you have heard a great deal about that so let me not repeat it.

But in addition to that, we are concerned about the tensions that could be created between the administrator of the hospital and the practicing physicians around such issues, for example, as arbitrarily shortening length of stay. In order, for example, to help the hospital offset its uncovered costs. The patients that have no reimbursement at all. We would anticipate that kind of pressure.

We would anticipate pressures for other patients to lengthen their stay so that they become outliers and become cost reimbursed. That may be true of any patient, but psychiatric patients and their physicians would be particularly vulnerable to that kind of pressure from administration.

We also share some concern from a State where prospective reimbursement has been underway for a long time in that it can spawn an enormous bureaucracy. Perhaps you have seen the studies that have been done in New York State that now indicate that $.25 out of every dollar spent in New York State for health care supports that regulatory bureaucracy. We understand the need for some regulation, but we see the potential in this system for expanding the dollars that go to the support of that kind bureaucracy rather than patient care.

We are worried about the impact of this new prospective reimbursement approach on new technology, and new biomedical research and its application in the hospital. This is particularly true in psychiatry. Three of the last Nobel Prize winners have received those awards as a result of brain research. This means that in relationship to the treatment of dementia, the treatment of Alzheimers disease. The CAT scan's equivalent for psychiatric patients, the PET scans are going to become increasingly important and very used. Where is the front end money, the incentive, to the hospitals to make that kind of equipment available as an application of new research findings going to be within this particular reimbursement methodology? We don't see that clearly.

Finally, Mr. Chairman, I would like to suggest as a part of our support, and wish to help you with this shared dilemma, that you look at some other things that the American Psychiatric Association has done, which we believe is less arbitrary than this particular method of prospective reimbursement. For example, the effect of our peer review program, which I know you are well aware of, that we now have underway with commercial insurers that have saved substantial amounts of moneys by good and adequate review of care. We do not believe that the possibilities of that approach, not only for quality of care, for savings in the cost of care have been explored.

We have mentioned to you some changes in medicare in terms of incentives to outpatients care that could be helpful.

I think we would want to end by saying that whatever methodology you adopt, we want it to be applied to the psychiatric patient as well. We do not want a different system of reimbursement worked out for the psychiatric patient because wherever that occurs, the psychiatric patient loses. The psychiatric patient is a patient like any other so we would endorse whatever approach you come out with, but we think that the psychiatric patients ought to have the equivalent study. We appreciate the current exemption for private psychiatric hospitals. We would like to see it extended to general psychiatric hospitals, but only until equivalent studies can be done there because we recognize that things have to be done to change the current reimbursement system.

Thank you, Mr. Chairman.

Senator DURENBERGER. All right. Thank you very much.

[The prepared statement of Dr. English follows:]

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STATEMENT
OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

ON

PROPOSALS TO ESTABLISH A PROSPECTIVE PAYMENT SYSTEM UNDER MEDICARE

PRESENTED BY

JOSEPH ENGLISH, M.D.

BEFORE THE

SUBCOMMITTEE ON HEALTH

SENATE FINANCE COMMITTEE

FEBRUARY 17, 1983

Mr. Chairman and members of the Subcommittee:

My name is Joseph English, M.D., and I am Chairman of the Council on Standards of Practice and the Economics of Psychiatric Care of the American Psychiatric Association. I am also Chairman of the Department of Psychiatry at St. Vincent's Hospital and Medical Center in New York City.

I am pleased today to have this opportunity to testify on behalf of the American Psychiatric Association, a medical specialty society representing over 27,000 psychiatrists nationwide, on the issue of prospective payment for hospital services, an issue which affects -- directly or indirectly -- countless numbers of individuals now diagnosed or to be diagnosed as mentally ill and many more individuals with a serious physical illness and a complicating mental disorder

At the outset, it is important to note that the APA shares Congress' concern with the spiraling cost of both public and private sector health care delivery, particularly in this time of budgetary crisis in the Social Security system and high unemployment. We believe, as does the AMA, that the public and private sectors must seek answers not only to the question of medical care cost, but also to the equally pressing question of access to quality medical care. It is incumbent upon us to reconcile both of these issues, without compromising either.

We recognize that the propsective payment approach outlined by the Secretary before the Committee just two weeks ago is one solution to run-away Medicare costs, just as "catastrophic health insurance" plans were several years ago, or "hospital cost containment" was in the not-too-distant past. However, as then, we must urge caution. Implementation of a nationwide program -- whether under Medicare and/or Medicaid, or stretching further to an "all-payor" approach -- without a full evaluation of an adequate number and range of demonstrations is imprudent. We urge evaluation to include looking at the impact of the demonstrations' payment methodology on the quality of care, not looking simply at cost-efficiency studies. We note, for example, last year's Government Accounting Office letter report to Senator Packwood (May 10, 1982) which noted: "There is a point when a reduction in reimbursement could adversely affect access to and/or quality of care for beneficiaries." The only recent data bearing on this issue and cited in the Secretary's Report on prospective payment, are preliminary at best, and sample only 59 DRG categories. The preliminary findings of the Abt Associates report did not address the question raised in the GAO report, nor do other evaluations of prospective payment systems to date.

Thus, Mr. Chairman, we do not, today, know what that turning point of reimbursement versus quality of care is.

We commend the Secretary for his thoughtful and deliberate exclusion of private psychiatric hospitals (and a number of other facilities) from the proposed DRG prospective payment system. We are gratified that he has recognized that DRG data were not "developed, tested, or applied in these types of facilities, nor do the DRGs group the case types and associated resources expended by these types of institutions."

There is, however, an anomoly here. While psychiatric hospitals per se have been excluded -- at least until an appropriate DRG profile can be developed and tested -- psychiatric units of general hospitals are clearly part and parcel of the proposed system. They are included notwithstanding the apparent admission by the Yale team that the 14 psychiatric diagnostic groupings contained in the Yale-developed DRG listing to be utilized under the measure, were themselves never validated in any setting, whether general hospital, general hospital psychiatric unit, or private psychiatric facility. We understand further that these 14 groupings have neither been subject to serious scrutiny in the New Jersey prospective payment experiment, or any others utilizing the Yale schema.

How, then, can this listing be seen as a valid and reliable measure of either the nature of a psychiatric diagnosis made in a general hospital, or a tool from which the Administration can calculate a fee schedule?

The validity of this listing is particularly critical for psychiatry where diagnosis per se is not always a good predictor of utilization and therefore of cost. Issues such as the severity of illness, not necessarily adequately encompassed by the DRG system, are of particular import in treating the psychiatric patient. In short, to badly quote Gertrude Stein, it is not always the case that "a psychotic is a psychotic is a psychotic."

Data have recognized wide disparities in length of stay for psychiatric patients -- both across type of facility and across diagnosis. This can be attributed to a variety of causes, including those regional variances cited by the Secretary, but also including the severity of the illness itself. We know, for example, that there is a significant difference between the length of stay for the psychiatric patient between the general hospital psychiatric unit and the psychiatric bed in a smaller general hospital. The DRG system would utilize an average length of stay to calculate payment. This does not appear to be a clinically sound reimbursement practice. It could be likened to providing the same base payment to a hospital which provides treatment to a coronary patient in a coronary care unit as contrasted to treatment in a general ward capable of providing coronary care. They are simply not comparable.

Yet another aspect of the length of stay issue as it affects the psychiatric patient relates to the availability of an outside support system for the patient. In New York, for example, absent such a support system, a patient may require a greater length of stay until either an appropriate home-based care system can be found, or a long-term care facility bed becomes available. The lower the level of outside support, as a whole, the more likely the onger the stay. The DRG system ostensibly factors in "routine treatment" with "complications." However, at what point does the routine become a complication, and moreover, at what point does a "complication" become an example of an "outlier" case, and therefore reimbursible at cost?

These questions are difficult to answer with respect to those portions of the DRG listing which have been tested and validated adequately. They are nearly impossible to determine with accuracy for the 14 psychiatric categories which have not necessarily been subjected to appropriate validation to date.

Without such validation, we would urge extreme caution and recommend against applying the DRG system at this time to psychiatric patients in any setting, not just those now proposed for exemption under the Administration's program.

We understand that the Administration plans to study how to bring psychiatric hospitals and other exempted categories under the proposed DRG plan in the future. We believe that treatment patterns for psychiatric patients as a whole including serious review of the "severity" issue -- regardless of their treatment setting -- should be reviewed carefully before being included under the DRG plan.

At the same time, we recommend that the Administration specifically and carefully scrutinize the so-called "outliers" within the proposed program -- the high-cost users of hospital-based services -- with an eye toward developing a more responsible, cost-effective means of managing such patients. We note, for example, that the costs of what has become known as "liaison psychiatry" would not necessarily be factored into a DRG reimbursement scheme, yet liaison psychiatry has been found in a growing number of studies to be a cost-effective, length-of-stay-reducing pattern of practice. Levitan and Kornfeld, for example, have found that in a year-long comparison of the post-operative course of a group of 24 elderly patients who had undergone surgery for repair of hip fractures and who had available liaison psychiatric services with a similar group of 26 patients who had the same kind of surgery but did not receive the liaison services, the group receiving psychiatric liaison care required an average of 12 fewer days of hospitalization (30 versus 42 days -- a 28.6 percent reduction). This resulted in an estimated savings of $193,000 over the course of that year (with the liaison services costing $10,000 for the same year). Moreover, twice as many patients who had psychiatric liaison services were able to return home rather than to nursing homes or other less cost-efficient institutional settings.

Similar findings were made by Mumford, Schlesinger and Glass in a review of 34 controlled studies investigating the effect of psychotherapy interventions on recovery from surgery and heart attacks. Their review found that on the average, psychotherapeutic intervention reduced hospitalization approximately two days below a control group's average of 9.92 days.

Mr. Chairman, I have appended these studies to my testimony and ask that they be made part of the hearing record.

We believe that interventions, such as provided by liaison psychiatry, could be lost as the result of the imposition of the DRG system which would not include such costs as part and parcel of routine medical treatment for a physical disorder. They are found to be cost-effective and a factor in legitimately reduced lengths of stay. They should have a place within the system, if it is to be enacted.

Yet another aspect of the "outlier" or high utilizer concept which has been identified in the literature is the fact that patients with untreated mental disorders are high users of medical care and that a secondary diagnosis of mental disorder often leads to an increased utilization of other medical care -- more often than not, repeated hospitalization. Under a DRG system, a hospital would have the opportunity to charge for treatment of a primary illness (the one for which the patient was actually hospitalized) or for the treatment of the secondary mental illness. Clearly, the higher-priced code would be chosen -- the physical disorder, again notwithstanding the fact that the treatment of and therefore reimbursement for the secondary mental illness could have actually saved other hospital-based health care costs.

I will turn to issues such as those implied by the foregoing paragraph, including issues of code manipulation, cost-shifting, multiple admissions, etc., in a moment. However, there is one potentially pernicious impact of DRGs which needs to be addressed in somewhat greater length: its impact upon technology development and health research.

Secretary Schweiker noted in his Report on Prospective Payment that PPS "will encourage hospitals and physicians to develop convincing evidence that costly new technologies are both efficacious and cost-effective... allowing new or more costly patterns of care to be introduced in a more systematic and deliberative fashion." The fallout from such a policy could be seriously damaging to this nation's biomedical and behavioral research community, and ultimately to the patients who migh benefit from such breakthroughs in technology. In the past, psychiatry has not been in the vanguard of technological advances. However, today, we are upon the threshhold of major breakthroughs in the diagnosis and treatment of dementia, of Alzheimer's disease. The PET scan -- the brain related relative of the CAT scan -- is now in prototype form. As both research outcomes and technology become increasingly available in our field, how can we be certain that these breakthroughs will have their appropriate and necessary impact upon the hospital-based practice of psychiatry under the current DRG proposal? Who will weigh the value of successful treatment against the cost of equipment? Who will determine a particular new technology's "cost-efficiency?"

Much of the current technological advance being made in psychiatry is aimed directly at the most chronic of the mental illnesses -- schizophrenia, organic brain syndrome, dementia. Many persons suffering from these disorders are treated more frequently in the general hospital setting -- particularly those suffering from organic brain syndrome and dementia. This burgeoning technological explosion is aimed at appropriate diagnosis of these disorders and charting clinical progress. New technology can help modify treatment costs downward, notwithstanding its initial costs for procurement.

Worst, if the system is set in place solely for Medicare populations, more often than not, those who could benefit to the greatest degress from these impending breakthroughs, could we not be establishing a two-tiered system of care, where the technology is available for those privately insured, and prohibited for the Medicare beneficiary?

Other issues which arise as the result of the proposed system have been mentioned by other witnesses before this Committee, but bear repeating, since they affect the Medicare psychiatric patient in the general hospital setting in as immediate a way as they do other Medicare patients in such facilities. They have a potentially pernicious effect upon matters such as quality of care, abuses of the system, private insurance carriers (including the insured population they serve) and ultimately the Medicare beneficiary him or herself.

In order to assure a positive-cost benefit to the hospital for the Medicare benficiary receiving treatment under a DRG system, hospitals have a number of options. Some of these may be decidedly positive, such as ensuring that unnecessary testing and services are not provided, or ensuring that, to the maximum extent possible, individuals are not kept in the hospital beyond a responsible recovery period for their specific illness (including some recognition of the severity issue). However, other methods of ensuring a "match" between Medicare patient and DRG reimbursement are potentially fraught with problems.

These include:

(1) arbitrarily shortening hospital stays by a day or two. This has the ironic effect, particularly in the elderly Medicare population, of likely leading to rehospitalization. Obviously, the hospital could then be reimbursed for each stay at the DRG-appropriate reimbursement level, in lieu of simply bearing the cost of an additional day or two of care beyond the DRG level, if warranted. This is clearly cost-ineffective, and also has repercussions for the beneficiary and his or her family.

(2) DRG code manipulation. This is a variant on the above-cited problem. In this case, a patient has several serious problems. The hospital may choose to treat all of them and be reimbursed for the most expensive DRG category. Alternatively, the hospital could choose to treat one illness, discharge the patient, readmit for a second diagnosed illness, treat, etc., and thereby be able to collect payment for each of the multiple disorders from which the older patient is suffering. Such a "revolving door" approach to hospital-based treatment is not only cost-inefficient, it is not good medicine.

(3) shifting Part A costs to Part B. In order to hold costs below a particular DRG reimbursement level, a hospital may require that tests and other diagnostic practices be completed on an outpatient basis, in lieu of the hospital setting. The patient is then admitted with the diagnostic charges being made to Part B, and therefore not applicable to the DRG reimbursement. This is a cost-shift within the Medicare system itself which, while not necessarily inappropriate, should be recognized for what it is: a shift, not a savings.

(4) extending hospital stays to the extent that a patient would qualify as an "outlier," and therefore be reimbursed on a cost basis. Short of such obviously extended stays, a hospital simply could shift cost above that provided by the DRG reimbursement level to other privately insured patients -- the "cost-shifting" about which this country's insurance industry is deeply concerned. The APA shares that concern, particularly since such cost-shifting could ultimately have a damaging effect upon private insurance benefits.

We believe that good utilization review -- peer review of the care rendered Medicare beneficiaries -- could help resolve some of these problems. However, we also believe that physicians alone do not bear the responsibility for the spiraling costs of hospital care for the Medicare patient. Hospitals and their administrators share in that responsibility. The setting of physician against hospital administration in an adversarial relationship rather than a partnership to render quality health care is a serious and real danger of this system if it is not carefully drawn.

Ultimately, the group which could suffer most seriously from such a situation is the Medicare patient.

What the Department of Health and Human Services plans to set into motion is a highly complex and regulatory system: complex but not enough to account for the severity of a patient's illness; and one which, notwithstanding the Secretary's comments to the contrary, will pose a regulatory nightmare of paperwork, both at the hospital level and at the level of DHHS. This is particularly true if, as has been proposed by some who have testified before the Committee, states are allowed to experiment beyond the Medicare population. How, under such myriad of experiments, can the Federal government ensure that Medicare Part A costs are not actually increasing, other than through detailed data-gathering far in excess of what we experience today?

Both the medical profession and the government want an efficient, cost-effective system of quality health care for the nation's elderly and disabled now under or soon to be under the Medicare program. We posit that some of the problem is inherent in the Medicare system itself which continues to place its emphasis on short-term acute-care hospitalization (and I emphasize hospitalization), in lieu of lower cost outpatient alternatives to that care. If, as the Secretary's Report notes, some hospital-based activities will and should be shifted to the out-patient sector, then Medicare Part B should be looked at carefully for gaps in such less costly outpatient care which leave no alternative to the medical profession but to hospitalize the patient.

Notable among these is the continued capping of benefits for the outpatient treatment of mental illness to a $250 Federal share, matched by a similar patient copayment. We know that the cost of elderly Medicare beneficiary outpatient charges (reasonable charge per enrollee) has increased more than fourfold since 1967 up from an average of $103.44 in 1967 to $416.92 in 1981). Yet there has been no recognition of the impact of such increased cost upon the treatment of mental illness. If we were to assume the same increase for the treatment of mental illness over the same 14 year period, the $250 limit is now worth 1/4 of what it was in 1967, or $62.50! That is hardly cost-efficiency. Little or no effective intervention for depression or other treatable, reversible disorders of the elderly can be provided at such a level. The alternative is more expensive, not always necessary, hospitalization.

As we have articulated before this Committee in the past in far greater detail, it has been demonstrated widely that there is a positive cost-benefit to the provision of outpatient psychiatric care, both in terms of offset physical health care costs, and in terms of productivity. In the context of the DRG hospital cost system and its potential diversion of patients from the inpatient to the outpatient setting, its cost-enhancing and medically appropriate benefits are shown in even bolder relief.

The implications of the limited outpatient psychiatric benefit under Medicare are evident as they relate to the DRG issue. They are even more difficult when one seeks to impose a "competition" health insurance proposal on the Medicare program. At the risk of repeating testimony presented previously before this Committee, I must note that it is true that people are not clamoring for better psychiatric benefits under Medicare. In part, this is based upon misperceptions about the nature of mental illness and its treatment; in part on an individual's denial of becoming the victim of mental illness; and in part, it is based upon stigma. Since mental illness, as all other illnesses, more often than not strikes in a random fashion, many of those not suffering now from such an illness are likely not to be thinking about insuring against such an illness in the future, particularly when they deny ever falling victim to mental illness despite epidemiological evidence of the incidence of mental illness. People often do not or cannot think about what level of benefits they may require at some point in the future under a particular health plan, and, unless they are insured against such an illness, the likelihood of greater costs -- both in less appropriate but insurable care, and in lost productivity -- is irrefutable.

Before I close, Mr. Chairman, I would like to pose a basic question regarding the philosophy underlying the DRG-prospective payment program. I wonder how fixing costs across facilities represents any movement toward the "competition" model proposed by the Medicare voucher concept and ultimately as proposed by members of the House and Senate and the Administration as a plan to encompass all health care. We find it difficult to reconcile these two proposals, and thus difficult to reconcile the prospective payment system with other proposed changes in the Medicare, Medicaid and private health insurance systems now pending before this Committee.

In sum, the APA urges extreme caution: caution in applying the DRG system to inpatient psychiatric care in the general hospital setting; caution with respect to the damages to biomedical research and technology development; caution with respect to the potential for abuse of the system, whether internally or as shifted to the private insurance sector; caution with respect to the shift to greater reliance on a severely restrictive outpatient psychiatry benefit; and caution with respect to the potential regulatory nightmare the proposal as now developed could create. The APA believes that there is a need to rein in runaway hospital costs under Medicare, but recommends that appropriate testing and validation of several methods be completed before launching a nationwide uniform program -- methods that look at both cost efficiency and its impact on the quality of care.

The APA looks forward to working with the Committee in developing appropriate responses to these critical issues. We appreciate the opportunity to have appeared before the Committee on this issue of such critical importance to medical care for the Medicare population.

Am J Psychiatry 138:6, June 1981

BRIEF COMMUNICATIONS

Clinical and Cost Benefits of Liaison Psychiatry

BY STEPHAN J. LEVITAN, M.D., AND DONALD S. KORNFELD, M.D.

A liaison psychiatrist participated in the postoperative care of a group of elderly patients who underwent surgery for fractured femurs. Clinical outcomes for this group were compared with a control group of patients who were not treated by a liaison psychiatrist. Length of stay for the treatment group was 12 days shorter than for the control group, and twice as many patients in the treatment group returned home rather than being discharged to a nursing home or other health-related institution; therefore, a substantial reduction in the cost of their medical care was effected. The authors suggest that psychiatric liaison services should be viewed as a potential cost containment mechanism for general medical care.

The field of liaison psychiatry has undergone great growth in the past decade. Reifler and Eaton (1) report that no less than 50 adult consultation liaison programs requested federal grant support for fiscal year 1977. While it is generally assumed that liaison services contribute significantly to improved patient care, few studies have been conducted to confirm this assumption. A review of the evaluation literature by Cohen-Cole (2) revealed only two studies of patient outcome. Dubovsky and associates (3) found a decrease in mortality on a coronary care unit where a liaison psychiatrist met regularly with the nursing staff. Adsett and Rudnick (4) found a decrease in the number of psychiatric hospitalizations and emergencies in a community-based family medicine practice after the addition of a liaison psychiatrist. The impact of liaison psychiatry on the cost of medical care has not been studied; however, one study of short-term outpatient mental health interventions found reductions in the utilization of medical care services as a result of these interventions (5). The cost of these programs appeared to be at least partially offset by the savings from the reduced medical care utilization.

Our liaison relationship with the orthopedic surgery service at Presbyterian Hospital afforded an excellent opportunity to study the clinical and cost benefits of liaison psychiatry. Elderly patients undergoing emergency surgery for fractured femurs are at high risk for postoperative psychopathology. Thomas and Stevens (6) studied the social effects of fractures of the neck of the femur in older patients and noted that such fractures frequently resulted in prolonged increased dependence.

Our study was designed to test the hypothesis that a liaison psychiatrist could improve clinical outcome and reduce the cost of medical care by favorably influencing the postoperative course of patients aged 65 or over undergoing surgery for fractured femurs. We predicted a reduction in the length of hospital stay and an increase in the number of patients who could return home after discharge.

METHOD

A liaison psychiatrist (S.J.L.), working part-time (10 hours per week), followed all patients aged 65 and over admitted to a female orthopedic surgical unit for emergency surgical repair of a fractured femur during a 6-month period (April–September 1977). Patients were seen within 72 hours of admission and followed

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and treated by the psychiatrist until discharge. The liaison psychiatrist, as a member of the treatment team, worked closely with the house staff, the nursing staff, the social service department of the hospital, the attending staff, the physiotherapy department, aides, volunteers, and family and friends.

Clinical outcomes were defined as 1) length of hospital stay, and 2) discharge disposition (the number of patients who were "discharged home" as opposed to the number of patients who were discharged to a nursing home or other health-related facility). Outcome data were obtained from the hospital record of each patient.

We will refer to the 24 patients followed by one of us (S.J.L.) as the liaison group and the 6-month intervention period as the experimental time period. The clinical outcomes in the liaison group were compared with the clinical outcomes in 26 patients who were not followed by a liaison psychiatrist but had been admitted to the same orthopedic unit during the same calendar months 1 year earlier for the emergency surgical repair of a fractured femur. We will refer to these patients as the control group and to their 6 months in the hospital as the control time period. Comparison of liaison and control groups revealed no significant differences in age distribution (t test) or preoperative levels of functioning (Mann-Whitney U test). All patients were ward patients. The same surgical technique was used for the repair of the fractured femurs of patients in both the liaison and control groups. To the best of our knowledge, with the exception of normal staff turnover, conditions on the unit were the same during the experimental and the control time periods.

To control for the possibility that any observed significant decrease in the lengths of hospital stay would be due to some factor other than the interventions of the liaison psychiatrist, we needed additional comparisons. If some factor was causing a decrease in hospital stays in general, one would expect a decline in the average length of stay for all patients admitted to the surgical unit. Therefore, the average lengths of stay for all patients receiving knee and hip surgery (excluding fractured femurs) during the experimental and control time periods were compared. The average lengths of stay for all patients receiving total prosthetic joint replacement (total knee and total hip) during the experimental and control time periods were also compared.

We used *DSM-III* criteria to formulate psychiatric diagnoses for patients in the liaison group. The following are brief clinical examples of psychopathological situations and typical interventions by the liaison psychiatrist.

Postoperative Delirium

An 87-year-old widow, living alone with some assistance from a neighbor, fell on a scatter rug. After surgery she was disoriented and delusional and had visual hallucinations. The liaison psychiatrist started her on thioridazine and her symptoms improved; he helped the patient and her family to understand that she was not senile (as they had feared). The family wondered if they should give up the patient's apartment, but they were reassured by the psychiatrist that her mental status would not deteriorate again. She was sent home after discharge, and a home health care attendant was provided.

Iatrogenic Organic Brain Syndrome

A 78-year-old retired actress, who lived with her partially blind sister and employed a part-time housekeeper, slipped on her newly waxed kitchen floor. After surgery she was mentally dull, lethargic, and somewhat ataxic, and her ambulation progressed very slowly. Postoperative orders for 30 mg of flurazepam at bedtime and 5 mg t.i.d. of diazepam had been renewed continually. After both drugs were discontinued on the recommendation of the liaison psychiatrist, her symptoms improved. The patient was discharged home to the care of her housekeeper and arrangements were made for a visiting nurse.

Postoperative Anxiety

An 80-year-old retired woman, living with her husband, fell while getting out of her bathtub. Postoperative attempts at ambulation were unsuccessful because the patient was extremely afraid of falling. She cried, required continuous reassurance, and refused to relinquish her special duty nurse. The liaison psychiatrist prescribed diazepam with the strong suggestion that it would help her to overcome her fear of walking. Gradually her fear abated and she was able to walk. Her daughter agreed to live in the patient's home temporarily, after which a housekeeper would assist the patient.

Family Counseling

An 85-year-old widow, living alone, slipped while getting out of the tub. After surgery she was frequently confused and disoriented in the mornings. Her son feared that she had become senile and prepared to give up her apartment and request permanent placement in an old age home. The liaison psychiatrist reassured him that the elderly often react to surgery in this manner and that it was usually temporary. The patient had been receiving chlordiazepoxide for sleep regularly since surgery; soon after it was discontinued and thioridazine substituted on the recommendation of the liaison psychiatrist, the patient's disorientation and confusion abated. The son agreed to the original plans to discharge the patient to her home.

Behavioral Management Problem

An 83-year-old widow, living with a friend, fell one night while wandering out of bed in a confused and agitated state. After surgery the patient became so noisy and agitated every night that she had to be wheeled into the hallway so that other patients could sleep. The staff and her friend became discouraged. A conference was held to formulate a vigorous treatment plan: 24-hour special duty nursing care was ordered, and the patient began taking haloperidol. The social service department of the hospital contacted the patient's sister, who agreed to visit regularly, and suggested that the friend bring in familiar objects from home. Soon, although still confused during the day, the patient was quiet and able to sleep at night. She was discharged home and continued to take maintenance doses of haloperidol.

Iatrogenic Depressive Reaction

An 82-year-old widow, living alone with the help of a part-time housekeeper, fell at home. After surgery the patient became apathetic and lethargic and experienced some loss of appetite. She admitted to feeling depressed and apprehensive. Previously unknown details of her history included successful treatment with imipramine within the past year for atypical facial pain; she had been receiving maintenance doses of imipramine until the time of admission. After surgery she became apprehensive that her maintenance imipramine had not been reordered, but she did not communicate her fears to the staff. Although aware that her mood was becoming more and more depressed, she did not associate this with the discontinuation of the imipramine. The patient was relieved when we discovered the oversight and restarted her imipramine immediately. Before long her mood improved, her appetite returned, and she looked forward to going home.

Liaison with Nursing and Physiotherapy Staff

A 73-year-old woman, living with her sister, slipped in the street. After surgery she was afraid to walk. Her ambulation proceeded so slowly that her nurses began to blame the patient and the physiotherapists avoided her. A conference was held at which the staff ventilated these feelings and formulated a treatment plan; after this the staff became enthusiastic about helping the patient. Staff members began to spend more time with the patient and learned much about her early life. The social worker contacted the members of the church choir in which the patient had sung and some began to visit her regularly. The program was a success, and the patient began to walk again. She was able to return home to her sister's care, which was supplemented by the visiting nurse service.

Depression Masquerading as Organic Brain Syndrome (Pseudodementia)

An 81-year-old widow, living with her daughter for the past 4 months, fell while visiting her own apartment. After surgery she appeared confused, distant, and apathetic and experienced a memory deficit for recent events. Her daughter and the staff were convinced she was becoming senile. The daughter considered giving up the patient's apartment and looking for an institutional placement. Closer scrutiny of the case revealed that the patient's husband had died 4 months previously. The liaison psychiatrist considered a diagnosis of retarded depression. After he met with the patient several times, she was able to cry and express her grief at the death of her husband; she also expressed guilt for having become a burden to her daughter. The staff was encouraged to offer attention and support. Efforts were made to have the grandchildren visit. The patient started taking amitriptyline, after which her thinking accelerated gradually and her memory for recent events improved. She was discharged to her daughter's home, and her return to her own home in the near future with help from a home health aid was planned.

Exacerbation of Schizophrenia

A 77-year-old woman was admitted to the neurology service for evaluation of confusion and agitation. Although restrained in a chair because of her agitated state, she fell to the floor. She was transferred to the orthopedic service. After surgery she experienced hallucinations and delusions. An interview with the family revealed a history consistent with paranoid schizophrenia. Haloperidol was effective in relieving her symptoms, and the patient was discharged to a rehabilitation facility.

Liaison with Social Service

A 77-year-old widow, living alone, fell at home. Because her medical history included a diagnosis of chronic schizophrenia, her application to a nursing home was rejected. The social service department conveyed the psychiatrist's opinion to the nursing home staff that the patient's schizophrenia was well controlled with haloperidol and that she would not be a management problem. As a result the application was accepted.

RESULTS

In the liaison group 17 patients demonstrated psychopathology, and 9 received more than one psychiatric diagnosis: organic brain syndrome, N = 10; adjustment disorder with depressed mood, N = 8; adjustment disorder with anxious mood, N = 7; major depressive episode, N = 1; and schizophrenia, N = 1. Because there was one death in the liaison group and three in the control group, for statistical analysis the sample size for each group was 23.

The lengths of hospital stay were compared by computing the difference between group medians. The median was 30 days for the liaison group and 42 days for the control group. The difference between the groups was significant (Mann-Whitney U = 185, $p<.05$).

In the liaison group 16 patients went home and 7 went to a nursing home or other health-related institution. In the control group 8 patients went home and 15 went to a nursing home or other health-related institution. The difference between the two groups was significant ($\chi^2 = 4.27$, $p<.05$).

We found no significant difference when we compared the lengths of stay for all patients receiving knee and hip surgery (excluding fractured femurs), even when an extremely liberal $\alpha = .1$ was used (Mann-Whitney U = 697, n.s.): during the control time period there were 33 patients who had a median stay of 17 days; during the experimental time period there were 44 patients who had a median stay of 19.5 days. The slight difference that existed was in the direction of longer hospital stays during the experimental time period.

We also found no significant difference when we compared the lengths of stay for all patients receiving total prosthetic joint replacement (Mann-Whitney U = 119, n.s.): during the control time period there were 18 patients who had a median stay of 21 days; during the experimental time period there were 19 patients who had a median stay of 25 days. The difference that existed was in the direction of longer hospital stays during the experimental time period.

The greater number of deaths in the control group, three as opposed to one in the liaison group, was not statistically significant.

DISCUSSION

As predicted, we found significant differences in both measures of clinical outcome between the liaison and control groups. The median length of hospital stay was 12 days less for the liaison group than for the control group, and twice as many liaison group patients were discharged home. Additional comparisons for control purposes demonstrated no general tendency toward shorter hospital stays during the experimental time period. In fact, if anything, these comparisons suggest a general trend toward longer hospital stays during this time period. It is, therefore, unlikely that some unrelated variable produced the reduced length of stay in the liaison group. We conclude with reasonable certainty that the observed decrease in length of hospital stays was attributable to the interventions of the liaison psychiatrist. Of course, shorter hospital stays in the liaison group may be in part a function of the enhanced ability of these patients to return home. Patients who are unable to return home may stay longer because they have to wait for a bed to become available in another institution.

The current average daily rate for hospitalization in the New York metropolitan area is greater than $200 a day. At $200 a day, an average reduction of 12 days per patient, for 23 patients, would amount to a savings of $55,200 over a 6-month period, or $110,400 per year. In the New York metropolitan area, the average costs for institutional care of the elderly vary from $300 to $500 a week, and the cost of home care averages no more than $200 a week. Therefore, home care offers a minimum savings of $100 a week. Eight more patients in the liaison group than in the control group were able to return home; assuming that all patients in our sample lived 1 year after discharge, a savings of $41,600 would accrue. If the study had been conducted for a full year, thus doubling sample size, the savings would have been $83,200. Hence, we estimate that the work of one liaison psychiatrist resulted in a projected savings of $193,600 over the course of 1 year. At the time of the study the psychiatrist's annual part-time salary was $10,000.

Psychiatric research in the general hospital presents well-known problems for experimental design. Methodologic considerations for defining independent variables, assigning controls, and measuring changes in dependent variables are difficult when studying patients who have complex medical or surgical illnesses. Therefore, a note of caution seems prudent. Although the observed differences in clinical outcomes of our two patient groups seem to be the result of the interventions of the liaison psychiatrist, it is possible that other variables may have contributed to these results. Additional studies of this kind are needed to confirm these findings.

Our results support the hypothesis that a liaison psychiatrist can improve clinical outcome and reduce the costs of medical care by favorably influencing the postoperative course of patients aged 65 or over undergoing surgery for fractured femurs. We hope that this study will serve as a stimulus for further research to demonstrate the clinical and cost benefits of liaison psychiatry in other settings.

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The Effects of Psychological Intervention on Recovery From Surgery and Heart Attacks: An Analysis of the Literature

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Abstract: A quantitative review of 34 controlled studies demonstrates that, on the average, surgical or coronary patients who are provided information or emotional support to help them master the medical crisis do better than patients who receive only ordinary care. A review of 13 studies that used hospital days post-surgery or post-heart attack as outcome indicators showed that on the average psychological intervention reduced hospitalization approximately two days below the control group's average of 9.92 days. Most of the interventions were modest and, in most studies, were not matched in any way to the needs of particular patients or their coping styles. Beyond the intrinsic value of offering humane and considerate care, the evidence is that psychological care can be cost-effective. (*Am J Public Health* 1982; 72:141–151.)

Introduction

Most studies of the effects of psychotherapy on utilization of medical services have considered ambulatory patients in office practices and health maintenance organizations (HMOs). However, there is also evidence that the patient's emotional status may influence the time it takes to recover from acute episodes of severe illness or from surgery. Such findings have obvious relevance for health care planning and financing.

The literature documents many ways in which psychological factors can influence health and the use of medical services, and three of these have particular relevance for patients in medical crisis: 1) emotional factors may influence the course of existing disease and recovery from medical crisis;[1–5] 2) the patient's emotional response to his/her disease may influence prescribing by the physician;[6,7] and 3) the patient's response to symptoms and to medical advice can influence the patient's subsequent management of his/her own disease.[8–12]

Impact of Emotions on Disease and Recovery

Kimball found that, of 54 adult patients admitted for open heart surgery, mortality was highest among patients who had been identified as "depressed" prior to surgery, although these patients were not at more risk on the basis of age, rating of cardiac functioning, or duration of illness.[13] Sime studied 57 women admitted for abdominal surgery and found that high levels of preoperative fear were associated with slower recovery, greater use of analgesics, and more negative emotions.[14]

Low morale was a significant predictor of death in the study by Garrity and Klein that assessed 48 patients for anxiety, hostility, and depression as compared with calmness and cheerfulness five days following admission to intensive coronary care. Of the 12 patients who died within six months of discharge, 10 had been characterized as suffering from unresolved emotional distress, and previous physical status did not explain the excess death rate among the depressed patients.[15]

Zheutlin and Goldstein studied 38 patients suffering major cardiac insult and reported that the combination of one Minnesota Multiphasic Personality Inventory (MMPI) scale and a cardiac status index predicted more than 70 per cent of the variance in patient recovery as assessed in a cardiac work evaluation unit.[16] Bruhn, Chandler, and Wolf found that 17 patients with myocardial infarctions who subsequently died had significantly higher MMPI depression scores than did survivors.[17]

Physician's Decision about Treatment

Kinsman, Dahlem, *et al*, have studied the patient's style of emotional response to asthma as it influences medical decisions about treatment.[6,7] Patients who scored high on a scale of "panic-fear symptomatology" tended to be kept in the hospital longer than low-scoring patients although objective measures of airway limitation did not indicate greater physiologic distress. These patients were often sent home on higher dosages of medication than were patients who had scored lower on the "panic-fear" scale. The differences in

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Editor's Note: See also related editorial, p 127 this issue.

medication were not explainable by objectively determined physical status.[6,15] High panic-fear patients may intimidate doctors into allowing unnecessary hospitalizations. Patients extremely low on panic-fear may, in denying symptoms, seek medical care only when in acute distress and at a point when hospitalization is required.[7,19]

Patient's Response to Medical Advice

Clinicians believe that a hopeful and cooperative patient tends to have a smoother and swifter recovery than a depressed and uncooperative patient. Yet the hospital experience, as it is currently structured, may interfere actively with the patient's willingness and ability to cooperate effectively to achieve recovery. Not told what to expect next, and admonished to rely on the experts, patients and their families are disadvantaged when they strive to cooperate. Some benefits from psychologically-informed intervention in the studies to be reviewed may reflect correction of defects in the social system in which recovery and recuperation are expected to take place. Preparatory education and restructuring delivery experiences enhance the ability of obstetrical patients to cooperate with their physicians.[20,21] The literature we analyze here suggests similar benefits from emotional and social support for patients recovering from medical and surgical crisis.

Materials and Methods

Meta-Analysis of Psychological Intervention

With the help of a Medlars search (1955–1978) and subsequent pursuit of key references through the Citation Index, we located 34 controlled, experimental studies in the published and unpublished literature that tested the effects of providing psychological support as an adjunct to medically required care for patients facing surgery or recovering from heart attack.[3,4,23–55]

The term "psychological intervention" covers a wide range of activities performed by psychiatrists, psychologists, surgeons, anesthesiologists, nurses, and others intended to provide information or emotional support to patients suffering disabling illness or facing surgery. These activities range from special programs to quite simple and inexpensive modifications of, or additions to, required medical procedures.

For example, in a study of the influence of psychological preparation for surgery, the evening before surgery 25 male patients discussed their concerns and fears in a small group led by a nurse. They were told what to expect and how to aid in their own recuperation. This group was contrasted with a randomly selected control group of 25 male patients who underwent similar surgical procedures with only the routine care. The experimental patients slept better, experienced less anxiety the morning of surgery, and recalled more details but fewer fearful or unpleasant images from the day of surgery. They suffered less postoperative urinary retention, required less anesthesia and pain medication, returned more rapidly to oral intake, and were discharged sooner than the control patients.[4]

In each of the studies reviewed, the recovery of patients who received information or emotional support in preparation for surgery, or during recovery from surgery or from heart attack, was compared with that of a control group not provided the special intervention. The Appendix Table summarizes the circumstances and findings of each study with the following information:

- patients sampled
- medical or surgical problem
- nature of intervention and provider
- sampling method used in the study
- size of experimental and control groups
- description of the outcome indicators
- effect size (ES) of the outcome indicators

The effect size (ES) of the outcome indicators is a standardized measure, the average difference between the treatment and control group on the outcome variable divided by the standard deviation of the control group. The ES can be interpreted in terms of the improvement or loss that the average member of the control group would experience if given the experimental treatment. A positive ES in the Appendix tables signifies the difference favors the group receiving the psychological intervention.[22]

Results

The ESs for all 210 outcome indicators in the 34 studies average +.49; the intervention groups do better than the control groups by about one-half standard deviation. These findings are consistent across studies; only 31 (15 per cent) of the 210 outcome comparisons were negative and 8 of the negative ESs are contributed by one study.[33]

Table 1 is based only on the 180 ESs derived from well-controlled studies that reported standard deviations. We exclude measures from studies that did not either randomly assign or carefully match experimental and control patients. We also exclude measures from studies that provided neither standard deviations nor statistics that allowed for their estimation.

Table 1 analyzes the ESs within 10 outcome categories segregating psychological self-reported "pain" variables and other-rated, physiological or "medical" variables. The ESs based on external indicators are, for the most part, larger than those for the self-ratings and average +.45 compared with +.35. The highest ESs are for cooperation with treatment, speed of recovery, and fewer post-hospital complications (events). One can conclude that in general cooperation with treatment influences both speed and uneventfulness of recovery, an observation also made by Ley in his review of studies of the effects of different types of pre-operative communications on various outcome variables.[36]

The "psychological interventions" described in the Appendix Table can be categorized in terms of their intended mode of action. Some studies tested educational methods and approaches designed to provide patients with information about their conditions and what to expect. Other studies tested various psychotherapeutic approaches intended to provide reassurance, to soften irrational beliefs, or in general

TABLE 1—Average Effect Sizes within 10 Outcome Categories

	Mean	S.D.	N*
Self Ratings			
1. Pre-op. anx., pain.	+.32	.73	6
2. Post-op. anx., pain.	+.38	.59	32
$\overline{ES}$ =	+.35		
Other Rating and External Indicators			
3. Cooperation with treatment	+.30	.40	11
4. Pre- & Post-op. pain-distress (other rated)	+.44	.46	43
5. Post-op. physiological indicators	+.28	.50	25
6. Post-op. narcotics, hypnotics, etc.	+.17	.42	13
7. Speed recovery	+.80	.50	17
8. Post-op. complications	+.38	.47	13
9. Post-hosp. course (events)	+.60	.34	10
10. Days in hospital	+.25	.28	10
$\overline{ES}$ =	+.45		N = 180
Grand $\overline{ES}$ =	+.43		

* Most studies included more than one outcome indicator category

to offer emotional support and relieve anxiety. Some studies offered interventions of both types. In the Appendix Table, reading down the third column "Nature of Experimental Group Intervention," one observes that psychotherapeutic approaches (ES +.41; s_{ES} .65; N 87) seem rather more effective than educational approaches (ES +.30; s_{ES} .51; N 56) which are also effective. A combination of both approaches seems clearly superior to either alone (ES +.65; s_{ES} .45; N 40).

A subset of the outcome indicators is particularly important for its cost implications. Thirteen studies reported 14 comparisons of the number of days hospitalized for the intervention and control groups. Ten of these studies provide adequate data for meta-analysis. The average difference in days of hospitalization for the 10 comparisons weighted equally is about two days in favor of the intervention group.* Table 2 summarizes these findings. It can be argued that studies with larger numbers of patients should be given more weight in deriving a composite. Reasoning also that a mean should be weighted inversely to its variance error, weighting each by the sample size would be appropriate. The average difference weighted for sample size and size of standard error equals 2.37 days, slightly higher than the unweighted average. Hence a reasonable estimate of the true difference between intervention and control groups favors the intervention group by more than two days.

Is this difference statistically reliable? The estimate of about two days shorter hospitalization for patients having psychological intervention is based on data from approximately 2,000 intervention and control patients across the four comparisons. Seven studies gave the standard deviation of hospital stay. The average standard deviation is 4.75 days and t = 7.32, significant at any reasonable level. If we analyze the findings using the study as the unit of analysis a significant t of 3.42 results.

We attempted to include the entire population of interest, i.e., all published and unpublished controlled experimental studies of the effects of psychological intervention in medical crisis.** One might suspect that unpublished studies would be more likely to contain negative results than would published studies. Smith attempted to study whether published studies are biased in favor of positive findings. She found that the average ES obtained by meta-analysis of data from published articles is about one-third larger than the ES from theses and dissertations that used comparable outcome indicators and subjects.[58] Two of the studies included in the Appendix Table are unpublished.[1,42] The effect sizes for one are slightly negative, for the other quite positive.

Discussion

It is important to recognize that these favorable effects prevail even though the interventions were mostly modest and not tailored to the needs of any individual patient. Since patients differ in the way they cope with emotional and physical threat, they might be expected to benefit most from interventions designed to complement their particular coping styles. The apparent superiority of providing both educational and emotional support may simply reflect increased chances of meeting the needs of more patients when two different types of intervention are offered.

A few studies offer evidence that the benefits of intervention are enhanced when the type of support provided is matched to the individual coping style of the pa-

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*One study not included in the analysis reported simply "shorter stay" for patients given information compared with control patients.[57]

**After we had completed our analysis, another study was published finding a 12-day shorter hospital stay for a treatment group compared with a control group of elderly patients operated on for repair of fractured femurs. Twice as many patients in the treatment group returned home rather than to another institution.[59]

TABLE 2—Duration of Hospitalization for Intervention and Control Groups for Fourteen Studies

Author(s) Medical Problem	Intervention Group		Control Group			
	Average days hospitalized	N	Average days hospitalized	N	Difference (Δ)	Standard Error$_\Delta$*
Archuleta, Plummer & Hopkins[1] (1977) Major surgery	7.49	248	6.90	267	−.59	.43
Fortin & Kirouac[36] (1976) Major surgery	6.44	37	6.35	32	−.09	.50
Langer, Janis & Wolfer[38] (1975) Major surgery	5.64	15	7.60	15	1.96	.37
Gruen[3] (1975) Myocardial infarction	22.50	35	24.90	35	2.40	1.43
Surman, *et al*[35] (1974) Cardiac surgery	13.40	20	17.00	20	3.60	**
Schmitt and Wooldridge[4] (1973) Elective surgery	9.70	25	11.80	25	2.10	1.07
Lindeman and Stetzer[39] (1973) Elective Surgery						
Adults	6.70	90	6.65	86	−.05	.45
Children	2.11	19	3.00	11	.89	.69
Lindeman and Van Aernam[40] (1971) Major surgery	6.53	126	8.44	135	1.91	.62
DeLong[42] (1971) Abdominal Surgery	6.17	31	7.18	33	1.01	.50
Andrew[44] (1970) Hernia surgery	6.91	22	6.78	18	.13	.95
Healy[*45] (1968) Abdominal surgery	—	181	—	140	5.00	**
Egbert *et al.*[*46] (1964) Abdominal Surgery	—	51	—	46	2.70	1.06
Kolouch[*51,52] (1962, '64) Elective Surgery	6.86	197	12.40	"many thousands"	5.54	.10

* Standard Error of the difference between the means equals $\hat{S}_p \times \sqrt{\frac{1}{n_i} + \frac{1}{n_c}}$ where S_p is the pooled standard deviation.

** Data insufficient to calculate Standard Error.

tient.[14,25,40,42,59] A patient who copes reasonably well with the help of denial may find detailed explanations about impending surgery or cardiac damage burdensome while another patient who copes with stress by seeking information and mastery could be reassured and helped by the same explanation.[42]

Surgical intervention or treatment on a coronary care unit may be viewed as a crisis as Whitehead defined it, "a dangerous opportunity." Analogous to the risks and benefits of medical and surgical interventions, the hospital experience itself may also be a dangerous opportunity for the patient's survival and subsequent social and emotional adjustment. The patient regaining his/her balance following a medical crisis can change direction and assume new and potentially better patterns of adaptation.[60-63] On the other hand, if the dangerous opportunity is not seized, needless incapacity may result. Survivors of heart attack range from the cardiac cripple to those whose emotional and social lives have been turned for the better.

The elaborate services provided in the surgical recovery room or the coronary care unit leave little to chance. They contrast markedly with the minimal attention systematically provided to educate patient and family for recuperation following hospitalization. In an action-oriented society, reports of the considerable effectiveness of modest interventions may command less attention than reports of the modest effects of more flamboyant interventions.

It is often argued that the medical care system cannot afford to take on the emotional status of the patient as its responsibility. Time is short and costs are high. However, it may be that medicine cannot afford to ignore the patient's emotional status assuming that it will take care of itself. Anxiety and depression do not go away by being ignored. The psychological and physiological expressions of emotional upheaval may be themselves disastrous for the delicately balanced patient or may lead to behavior that needlessly impedes recovery when surgery or medical treatment was otherwise successful.

Usually advances in medical knowledge call for large investments in training, personnel, and equipment if patients are to benefit. Thus, a measure that promises to benefit patients and to save money at the same time is newsworthy.

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APPENDIX

APPENDIX TABLE—The Effects of Psychologically-Informed Intervention on Recovery from Medical Crisis[a]

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
Flagherty & Fitzpatrick[23] (1978)	Adults: Major surgery	Relaxation technique at 1st attempt to get out of bed, post-op. nurse	Random: n_1 = 21 n_2 = 21	a. Post-op. Demerol	+ .76
				b. Incision Pain	
				1. Intensity	+ .95
				2. Distress	+2.70
				c. Change in blood pressure	
				1. Systolic	+ .03
				2. Diastolic	− .10
				d. Change in pulse rate	+ .27
				e. Change in respiration	+ .80
Finesilver[24] (1978)	Adults: Cardiac catheterization and coronary cineangiography	Specific information and emotional support, 2 sessions: 1. At admission 2. Day before surgery; by investigator	Random: n_1 = 20 n_2 = 20	a. Medication administered during surgery[c]	+1.22
				b. Mood adjective checklist	
				1. Well-being	+ .04
				2. Happiness	+ .14
				3. Fear	+ .11
				4. Helplessness	+ .19
				5. Anger	+ .16
				c. Distress during hospitalization (nurse's rating)	+ .74
				d. Cooperation during catheterization (nurse's rating)	+ .17
				e. Post-catheterization rating by patients of how "upset" they were by procedure	+ .24
Archuleta, Plummer and Hopkins[1] (1977)	Adults: Major surgery	Preoperative teaching by nurse plus 5 min. reinforcement.	Random: n_1 = 248 n_2 = 267 In 11 hospitals	a. Days hospitalized	− .15
				b. Analgesics used	− .09
				c. Forced vital capacity	− .10
				d. Maximal midexpiratory flow	+ .02
				e. Forced expiration volume at 1 second	− .05
Felton, Huss, Payne et al.[25] (1976)	Adults: 1st time major surgery under general anesthesia	1. Preoperative information by nurse, photographs and films, average time 88 min.	Random: n_1 = 25 n_2 = 25	a. Days hospitalized[d]	—
				b. Ventilatory function	
				1. 24 hrs. post-op	+ .05
				2. 48 hrs. post-op	− .38
				3. 72 hrs. post-op.	− .25

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention: Duration; Provider	Sampling Method: n_1 = size of experimental group[a] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
				c. Heart or circulatory complications[c]	+ .60
				d. Multiple affect adjective checklist (anxiety)	+ .28
				e. Personal orientation inventory	
				1. Inner-directedness	+1.53
				2. Self-regard	+ .87
				3. Acceptance of aggression	+ .33
		2. Therapeutic communication approach by nurse, average time 62.5 min.	Random: n_1 = 12 n_2 = 25	a. Days hospitalized	0.00
				b. Ventilatory function	
				1. 24 hrs. post-op.	0.00
				2. 48 hrs. post-op.	− 0.48
				3. 72 hrs. post-op.	− .71
				c. Heart or circulatory complications	+1.45
				d. Multiple affect adjective checklist (anxiety)	+ .17
				e. Personal Orientation Inventory	
				1. Inner-directedness	0.00
				2. Self-regard	− .53
				3. Acceptance of aggression	− .85
Fortin and Kirouac[26] (1976)	Adults: Major surgery	Preoperative education and training by nurses 1 session per week starting 15–20 days before hospitalization	Random: n_1 = 37 n_2 = 32	a. Inpatient ambulatory activity	+ .43
				b. Activities of daily living	
				1. 10 days post-op.	+ .83
				2. 33 days post-op.	+ .79
				c. Days before return to work or usual level of activity	+ .42
				d. Analgesics	+ .63
				e. Absence of pain and nausea at discharge	+ .69
				f. Satisfaction with hospitalization[e]	—
				g. Days hospitalized	+ .05
				h. Days lost from work in 33 post-op. days[e] Exper. = 23.8 days Control = 26.0 days	—
				i. Readmission or death	0.00
Auerbach, Kendall, Cuttler, et al.[27] (1976)	Adults: Dental surgery	Audio-tape of specific information about surgery by dental student	Random: n_1 = 29 n_2 = 19	a. State anxiety	
				1. Immediately after intervention	− .38
				2. Immediately after surgery	+ .22
Gruen[3] (1975)	Adults: Myocardial Infarction	Eclectic Verbal: Psychiatrist, ½ hr. a day for 5–6 days "to awaken hope"	Random: n_1 = 35 n_2 = 35	a. Days hospitalized	+ .23
				b. Days in intensive care	+ .49
				c. Days on monitor	+ .36
				d. Number of patients with congestive heart failure	+ .40
				e. Congestive heart failure, days per patient	− .02
				f. Number of patients with arrythmias	+ .50
				1. Ventricular	+ .50
				2. Supraventricular	+ .85
				g. Nurse ratings	
				1. Chest pain	+ .09
				2. Other pain	− .41
				3. Depression	+ .25
				4. Anxiety	− .16
				5. Refusals of treatment	− .28
				6. Weakness, exhaustion	+ .48
				h. Physician ratings	
				1. Depression	+ .33
				2. Anxiety	− .05
				3. TMAS Bendig Score	+ .06
				4. ST Anxiety Inventory	+ .14
				5. MAACL Anxiety	+ .14
				i. Nowlis Adjective Checklist	
				1. Anxiety	+ .09

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
				2. Surgency	+ .65
				3. Elation	+ .32
				4. Affection	+ .54
				5. Sadness	+ .32
				6. Vigor	+ .30
				j. Four-month follow-up	
				1. Anxiety	+ .71
				2. Retarded activity	+ .42
Langer, Janis and Wolfer[28] (1975)	Adults: Major Surgery	Combination RET (Ellis) and learning theory (Kanfer), psychologist, 20 minutes	Random: n_1 = 15 n_2 = 15	a. Nurses' ratings	
				1. Anxiety	+ .51
				2. Ability to cope	+1.15
				b. Per cent of subjects requiring[c]	
				1. Sedatives	+ .90
				2. Pain relievers	+1.15
				c. Days hospitalized[d] Exper. = 5.64 days Control = 7.60 days	—
	Adults: Major Surgery	Preparatory information only, psychologist 20 minutes	Random: n_1 = 15 n_2 = 15	a. Nurses' ratings	
				1. Anxiety	− .62
				2. Ability to cope	− .30
				b. Per cent of subjects requiring[c]	
				1. Sedatives	+ .63
				2. Pain relievers	+ .42
				c. Days hospitalized[d] Exper. = 7.2 days Control = 7.6 days	—
Melamed and Siegel[29] (1975)	Children: Tonsils, hernia, urinary surgery	Film: "Ethan Has an Operation", 12 min.; Actors	Matched: n_1 = 30 n_2 = 30	a. Measures taken post-intervention, but immediately pre-op.	
				1. Anxiety scale of Personality Inventory for Children	+ .67
				2. Behavior Problems Checklist (not taken)	—
				3. Palmar Sweat Index	+ .75
				4. Hospital Fears Rating Scale	+ .75
				5. Observer Rating of Anxiety	+ .60
				Observer Rating of Anxiety	0.00
				Observer Rating of Anxiety	0.00
				b. Measures taken 20 days Post-op.	
				1. Anxiety Scale of Personality Inventory for Children	+ .50
				2. Behavior Problems Checklist	+ .80
				3. Palmar Sweat Index	+ .60
				4. Hospital Fears Rating Scale	+ .75
				5. Observer Rating of Anxiety	+ .60
				Observer Rating of Anxiety	0.00
				Observer Rating of Anxiety	0.00
Wolfer and Visintainer[j][30] (1975); Visintainer and Wolfer[31] (1975)	Children: Elective surgery	"Psychologic preparation and support" by same nurse 1 hour across 6 points in time during hospitalization	Random: n_1 = 45 n_3 = 35	a. During blood test	
				1. Anxiety	+ .70
				2. Cooperation	+ .60
				b. During pre-op. medication	
				1. Anxiety	+1.32
				2. Cooperation	+1.20
				3. Pulse rate	+1:07
				c. During transport to O.R.	
				1. Anxiety	+ .52
				2. Cooperation	+ .51
				d. While in O.R.	
				1. Anxiety	+ .58
				2. Cooperation	+ .63
				e. Ease of fluid intake	+ .43
				f. Minutes to first voiding	+ .85
				g. Recovery room medication	+ .65
				h. Post-hospital adjustment	+ .90
Johnson and	Children:	Puppet therapy 1 time pre-	Random:	a. Palmar Sweat Index Change Score	

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
Stockdale[32] (1975)	Assorted surgery	operation, mean duration 13.4 min. by "The experimenter"	$n_1 = 22$ $n_2 = 21$	1. From pre-therapy to immediate post-therapy	+ .27
				2. From pre-therapy to night after surgery	+ .23
Rahe, O'Neil, Hagan, et al.[33] (1975)	Adults: Mycardial infarction	Four to six group therapy sessions, psychiatrist, during early rehabilitation	Mostly random, well-matched $n_1 = 36$ $n_2 = 21$	a. Number of coronary disease events 18-month follow-up post-infarction[c]	
				1. Coronary insufficiency	+ .61
				2. By-pass surgery	+ .63
				3. Reinfarction	+1.16
				4. Mortality	+ .58
				b. Knowledge of etiological factors in heart disease	+ .79
Field[34] (1974)	Adults: Orthopedic surgery	Hypnotherapy recording by "Research Assistant" who interviewed patient, 20 minutes plus interview	Random: $n_1 = 30$ $n_2 = 30$	a. Nervousness (rated by physician)	+ .37
				b. Speed of recovery	+ .06
Surman, Hackett, Silverberg, et al.[35] (1974)	Adults: Cardiac surgery	One or more therapeutic interviews, including teaching of autohypnosis 60–90 minutes	Random: $n_1 = 20$ $n_2 = 20$	a. Post-op. Complications	
				1. Delirium	+ .15
				2. Cardiac failure	− .11
				3. Hepatic dysfunction	+ .60
				4. Arrhythmias	0.00
				b. Post-op. Medication	
				1. Narcotic doses	− .41
				2. Morphine units	− .30
				3. Darvon doses	− .02
				4. Sleep medication	− .11
				5. Valium amount	+ .16
				c. Patient's State 5 days post-op.	
				1. Anxiety	− .14
				2. Pain	− .40
				3. Depression	− .75
				d. Days hospitalized[d] Exper. = 13.4 days Control = 17.0 days	—
Vernon and Bigelow[36] (1974)	Adult Males: Hernia repair surgery	Information recording re: hernia surgery and recovery heard twice pre-surgery plus encouragement to ask questions (investigator not specified)	Random: $n_1 = 20$ $n_2 = 20$	a. Pre-op.	
				1. Mood[c]	
				(1) Fear	0.00
				(2) Worry or fear of pain	+ .78
				2. Patient's confidence in doctors and nurses	+ .27
				b. Post-op.	
				1. Mood[c]	
				(1) Anger	+ .14
				(2) Depression	+ .36
				(3) Fear	+ .16
				2. Confidence in doctors & nurses	+ .22
Vernon and Bailey[37] (1974)	Children: Minor elective surgery	Film showing children going through induction of anesthesia without fear, approximately 45 min. by MD investigator	Random: $n_1 = 19$ $n_2 = 19$	a. Global Mood Scale, fear rating	
				1. Entering operation suite	+1.11
				2. Entering operating room	+1.10
				3. First minute of surgery	+ .70
				4. Until surgical anesthesia level reached	+ .50
				5. Anesthesiologist's rating of patient's fear	+ .46
Schmitt and Wooldridge[4] (1973)	Adult males: Elective surgery	Nurse investigator's small group therapy session evening before surgery. 1 hour for 19 experimental subjects; and added individual 15 to 60 min. session with nurse the morning of surgery.	Random: $n_1 = 25$ $n_2 = 25$	a. Self-report of anxiety on morning of surgery	+1.73
				b. Ability to void post-op.	+1.50
				c. Post-op. blood pressure	+1.10
				d. Amount of analgesics used	+ .78
				e. Number of days to resume oral intake	+ .21
				f. Days hospitalized post-op.	+ .55
Lindeman and	Adults: Elective	Pre-op. visits by operating	Random:	a. Days hospitalized	− .02

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
Stetzer[39] (1973)	surgery	room nurses; reassurance and information	n_1 = 90 n_2 = 86	b. Analgesics used within 48 hrs. post-op.	− .22
				c. Problems in emerging from anesthesia	+ .23
				d. Anxiety pre-op.	+ .09
				e. Anxiety post-op.	+ .19
	Children:	Structured pre-op. teaching by nurses	Random: n_1 = 19 n_2 = 11	a. Days hospitalized	+ .30
				b. Analgesics used within 48 hrs. post-op.	+ .56
				c. Problems in emerging from anesthesia	+ .36
				d. Anxiety pre-op.	+ .21
				e. Anxiety post-op.	+ .46
Lindeman and Van Aernam[40] (1971)	Adults: Chest and abdominal surgery	Structured pre-op. teaching by nurses	Random: n_1 = 126 n_2 = 135	a. Days hospitalized	+ .34
				b. Analgesics used within 48 hrs. post-op.	− .02
				c. Maximal expiratory flow rate	+ .47
				d. Vital capacity	+ .35
				e. One second forced expiratory volume	+ .35
Aiken and Henrichs[41] (1971)	Adult males: Heart surgery	Modified systematic desensitization (Wolpe and Lazarus) Nurses, plus 15 min. tape recorded relaxation exercise	Matched: n_1 = 15 n_2 = 15	a. Psychosis post-op.	+ .87
				b. Anesthesia time	+ .72
				c. Units of blood	+1.00
				d. Degrees of hypothermia	+1.03
				e. Duration of hypothermia	+ .62
				f. Mortality (3/15 = 3/15)	0.00
				g. Minutes on bypass machine	+1.41
DeLong[42] (1971)	Adults, female: Elective abdominal surgery	Specific information about condition, surgery and recovery given by psychologist	Random: n_1 = 31 n_2 = 33	a. Days hospitalized	+ .54
				b. Physical recovery	+ .65
Layne and Yudofsky[a] [43] (1971)	Adults: Intracardiac surgery	Therapeutic interview evening before surgery	Sample of convenience: n_1 = 42 n_2 = 19	a. Psychosis post-op.[c] Exper. = 10% Control = 22%	+ .51
Andrew[a] [44] (1970)	Adult males: Hernia surgery	Informational tape recording, 8 minutes, by psychologist	Sampling method unclear: n_1 = 22 n_2 = 18	a. Days hospitalized	− .04
				b. Amount of medication	+ .11
Healy[a] [45] (1968)	Adults: Abdominal surgery	Preparation for post-surgical experience, by nurse	Sampling method unclear: n_1 = 181 n_2 = 140	a. "Discharge earlier than norm"[d]	+3.28
				b. Narcotics required[e]	—
				c. Post-surgical complications	+ .92
Lazarus and Hagens[a] [46] (1968)	Adults: Open-heart surgery	Interview 1 hr. plus consultation with staff and changes in recovery room procedures	Sample of convenience: groups in two different hospitals n_1 = 21 n_2 = 33	a. Per cent patients with psychosis post-op.[c]	+ .65
Cassell[47] (1965); Cassell and Paul[h] [48] (1967)	Children: Cardiac catheterization	Puppet therapy before and after catheterization; child clinical psychologist.	Random: n_1 = 20 n_2 = 20	a. Disturbance during catheterization	+ .82
				b. Willingness to return to hospital	
				1. 3 days post-op.	+ .08
				2. 30 days post-op.	+ .23
				c. Behavior adjustment post-hosp.	
				1. 3 days	+ .08
				2. 30 days	+ .05
				d. Days 1 and 3 observation	
				1. Mood	+ .40
				2. Anxiety	+ .36
				3. Anxiety	+ .86
Mahaffy[f] [49] (1965)	Children: Tonsilectomy and ad-	Information and support to mothers by nurse at admis-	Random: n_1 = 21	a. Post-op.	
				1. Ability to take fluids orally	+1.96

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
	noidectomy	sion and when child returns from recovery room.	n_2 = 22	2. Vomiting 3. Crying before bedtime 4. Crying after bedtime b. Post-hospital Questionnaire 1. Fever 2. Called doctor to home 3. How long before child "recovered" 4. Child's behavior worries mother 5. Child's sleep disturbed 6. Fear of doctors and nurses 7. Fear of leaving mother 8. Crying	+1.12 +1.01 + .90 + .84 + .52 + .79 + .83 +1.31 + .36 + .28 + .30
Dumas and Leonard[e] [50] (1963)	Adult females: Gynecologic surgery	Nurse visited one hour before surgery, accompanied patient to surgery and remained until the patient was on OR table.	Unspecified: n_1 = 31 n_2 = 31 Total over 3 experiments	a. Post-op. vomiting[c]	+1.10
Kolouch[e] [51,52] (1962, 1964)	Adults: Elective surgery	Hypnotherapy prior to surgery and suggestion while patient still under anesthesia; by surgeon investigator.	Sampling method unclear: 100 cases selected by experimenter	a. Post-operative analgesics[d] b. Days hospitalized[g]	— + .70
Egbert, Battit, Welch, et al.[5] (1964)	Adults: Abdominal surgery	Information and reassurance by the anesthesiologist night before surgery plus visit by the same anesthesiologist post-surgery	Random: n_1 = 51 n_2 = 46	a. Amount post-op. morphine[j] b. Amount of pain[j] c. Days hospitalized	+ .51 + .40 + .67
Bonilla, Quigley and Bowers[e] [53] (1961)	Adult males: Knee surgery	Hypnotherapy pre-surgery by operating surgeon, 100 minutes total except for post-surgical hypnotism needed for 2 patients	Consecutive cases for each group: n_1 = 9 n_2 = 40	a. Average rehabilitation time[a] b. Post-op. narcotic[d]	+1.31 —
Vaughan[e] [54] (1957)	Children: Strabismus surgery	Reassurance and explanations by surgeon on admission for 15–25 minutes, repeat visits by surgeon 3rd and 5th days post-op., for 10–15 min.	Matched: n_1 = 20 n_2 = 20	a. Disturbed behavior[c] 1. Immediate post-op. 2. 7 days post-op. 3. 26 weeks post-op.	 + .37 + .90 +1.15
Goldie[e] [55] (1956)	Adults and Children: Requiring surgery or orthopedic procedure in ER	Hypnosis treatment as adjunct to or substitute for anesthesia; the physician handling the patient.	Sample of convenience: n_1 = 210 n_1 = 178	a. Administration of general or local anesthetic for[c] 1. Incisions 2. Removal of foreign body 3. Suturing 4. Reducing fracture or dislocation	 + .31 + .89 + .47 +1.34

FOOTNOTES TO APPENDIX TABLE

[a] Some authors published more than one article about the same studies and from these, only non-duplicated findings are reported. Studies that tested the effect of emotional support for a mother on recovery of child-patient were included. Studies that tested the effect of support for a mother of a child-patient on the subsequent comfort of the mother were not included.

[b] The group sizes for some studies change slightly for different outcome variables.

[c] Values transformed from percentages to metric numbers by probit transformation.

[d] Means and standard deviations needed to compute ES not available in published study.

[e] These ESs are derived from studies that did not assign patients to experimental and control groups randomly or through adequate matching or are approximated through probit transformation. They are excluded from the analysis reported in Table 2.

[f] Only the outcome variables listed were reported in sufficient detail to permit computing ES.

[g] This largest ES for hospital stay was computed from probit transformed dichotomous data. The author does not describe how the "norm" for expected hospital stay was determined. The analysis reported in Table 2 omits this finding.

[h] Three outcome measures relating to recall of surgery are omitted. The ESs are large and favor the intervention group but the benefit of recall is uncertain. The same findings are reported in Cassell's study.[47]

[i] Author reports findings for five types of surgery but data are sufficient to permit computing ES for only two—hernia and thyroid. We present the average ES for these two as a conservative estimate of the effects obtained.

[j] Authors report 24-hour morphine usage for five post-op. days and four measures of post-op. pain. Since the ESs are quite similar and redundant, we substitute the average ES for each set. The S.D.s needed to compute the ESs could be estimated from the data presented.

[k] S.D. could be estimated from other data to compute ES.

EDITORIAL COMMENT ON THE MUMFORD, SCHLESINGER AND GLASS ARTICLE

In their article, "The Effects of Psychological Intervention on Recovery from Surgery and Heart Attacks: An Analysis of the Literature," published in this issue of the Journal,[1] Mumford, Schlesinger, and Glass have made an important contribution to our understanding regarding the role of interpersonal skills in medical and surgical care. Most residency training programs have been designed so that knowing when and how to perform a procedure or which medicine to prescribe are adequate abilities. Skills in communicating with patients have generally been viewed as necessary, but unimportant or placebo aspects of patient care which are learned through experience. As the "art" of medicine, such techniques cannot be scheduled nor taught, or so the stereotype goes; and they have no particular influence on patient outcomes. This careful review article sheds serious doubt on such notions.

The authors have drawn on a widely distributed literature for their review. Reports came from journals which serve primary care physicians, pediatricians, internists, surgeons, psychiatrists, immunologists, psychosomatic medicine, anesthesiologists, dentists, nurses, psychologists, and medical social scientists. The isolation of these investigators in a variety of fields has probably impeded their influence on medical and surgical practice.

Another valuable contribution by the authors has been to subdivide the general area of interpersonal skills management into: 1) education and 2) one-to-one interactions, such as discussion regarding the patient's questions and concerns—sometimes referred to as counseling or (in mental health jargon) supportive psychotherapy. Lumping all interpersonal skills into one broad category serves only to obfuscate the complex issues involved. It is of interest that the data support the utility of applying both approaches, rather than employing just education or just a psychotherapeutic modality.

What are the implications of these findings for the health field? First, we must be much more concerned about training health professionals in interpersonal skills, such as education, counseling, and relaxation techniques. This is especially true for those fields in which the primary emphasis has been on the acquisition of biomedical information and technical skills. These disciplines include dentists, most physicians and surgeons, and many nurses. This is not to say that these professional groups must become "compleat" psychotherapists; however, they must be able to educate and counsel patients about the medical interventions and technical procedures which they perform. Merely exposing students and trainees to experienced clinicians does not guarantee either that they will acquire interpersonal skills adequate to their tasks, or that they will understand the importance of such skills on patient outcomes. In this regard, the National Board of Medical Examiners has recently established an Interpersonal Skills Task Force to generate test items which address this important area.[2] It appears that, at least at the level of certification and licensure, there is a growing awareness regarding the importance of these skills for professional competence.

An important corollary issue involves the assignment of clinical responsibility for interpersonal skills in health services. It seems likely that in time both consumers as well as administrators of health services will recognize the importance of such transactions to patient outcomes. If health professionals do not discharge these responsibilities during their provision of services, it seems likely that others will be hired and trained to meet them. This can only add to the cost of medical care, as well as to the fragmentation and depersonalization of health services.

Another implication of this report concerns economics. The authors have demonstrated that the provision of education and brief psychotherapies tended to reduce cost, while also reducing morbidity and mortality. Yet, the recent trend in health care insurance has been to reduce or refuse recompense for such services. It is not likely that a fee submitted by a physician or surgeon for counseling or education would be honored, nor that a hospital administrator would permit nursing time to be devoted to similar endeavors. Thus, our current economic, political, and administrative structures obstruct the implementation of these findings.

As with most innovative studies, these findings raise new issues for us. In particular, further attention should be paid to the minority (15 per cent) of the findings which do not support the hypothesis. As the authors indicate, we should not assume that education and counseling are necessarily good for everyone despite general trends. We need to know when the application of these interpersonal skills is either unnecessary or even counterproductive. So-called Hawthorne effects, stemming from such nonspecific factors as increased staff-patient interactions, may account for much or all of the observed differences. There remains the possibility that other data supporting the null hypothesis have not been published, given the difficulty in publishing such reports.

Many humanistic and/or experienced clinicians will view these data as merely explicating the obvious. For many others involved in the provision of health services, the results are not so obvious. As the Chinese-American medical anthropologist Francis Hsu has observed, "The Chinese accept science if it is clothed as magic, while Americans accept magic if it is clothed as science." Many health practitioners view the application of interpersonal skills in clinical interactions as evidencing more of the magic of medicine rather than its skillful and scientific application. We need such studies as these to provide enlightened and effective health services which are both humanistic and scientific.

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Senator **Durenberger**. Are either of the two associations represented here on record with this committee in support of any prospective reimbursement proposal for part A as we sit here today on February 17? We have been at this now for a year or more. The Chairman of this committee has been making that speech he made this morning for at least that period of time. We mandated in TEFRA an analysis of prospective reimbursement. We got the Secretary to come out with recommendations in a relatively brief period of time. We had hearings last summer on this. There is no question that at least this committee—and I think the Ways and Means Committee and other people on the House side—are headed for the prospective payment. And the question before us is what form should it take.

This hearing is for reaction to the administration's proposal. But my question is are either of these two major associations of health care providers on record currently with a prospective reimbursement proposal.

Dr. Schenken.

Dr. **Schenken**. Senator, we are not in the hospital business quite clearly. We are physicians taking care of patients, and lots of them in hospitals. We are on record as supporting the consideration of prospective reimbursement. We have just testified that we would be willing to exist within the 223 limitations, but I think we must be assured that any prospective reimbursement program leads to the type of care that you and we want. And, therefore, I think our suggestions have been toward that end, but probably not such that we would present a plan for hospital reimbursement per se as that is not our primary focus.

Senator **Durenberger**. Well, what is it then, Dr. Schenken, that is in the final stages that you have indicated in response to the Chairman's questions?

Dr. **Schenken**. Well, the American Medical Association developed last year a plan to develop a national health agenda that is multifaceted involving business and labor and many other major groups, including the physicians and hospitals. We hope when they come up with their final program, at the end of this year, that there will be guidelines that will help us and you in charting the course.

Senator **Durenberger**. Well, maybe when you said the end of the year, that answered my questions because by the end of the year we are going to have some form of prospective payment. It doesn't make any difference whether you have a component in there on part A financing or not.

Dr. **English**. Mr. Chairman, I welcome the question because I think the American Psychiatric Association would recommend a different approach to you based on our own experience. We would consider prospective reimbursement to be an arbitrary methodology that you may be forced to embrace. In contrast, a good peer review.

Our own experience with peer review shows that the adequate review of care can have major cost effective implications as well as qualitative ones. That's been our experience.

Senator **Durenberger**. You are talking about peer review in connection with a cost based reimbursement system?

Dr. **English**. That's correct, sir.

Senator **Durenberger**. All right. Dr. Primich.

Dr. **Primich**. Sir, you will have to excuse me for being relatively negative, but my purpose in being here was to express the experience of the New Jersey physicians who, we feel, are perhaps better able as a group to judge what is happening with the New Jersey system.

Now it has been projected without any substantiation, the major impartial evaluation group, HRET, has—as of now, their conclusions are inconclusive. So, quite obviously, there is nothing of substance that this experiment can be judged on, as yet.

The initial front loading of the system put the hospitals in a pretty good position. And, I am constantly hearing about how well the hospitals did last year, publicly. Privately, from the hospitals I am hearing about how tight things got this year and the threat to their survival next year. And, this whole approach where the New Jersey Hospital Association went from opposition to neutrality to support, back to neutrality—and my prediction is that if you can just be patient, you will find them back to a very strong opposition because this program—the built in ratchet is going to be very, very detrimental, and its effect is already being felt by the physicians where we are being mildly, at this stage, pressured to discharge marginal patients ahead of time to save that day, to not admit—and this is the big one as far as I am concerned. It's what I refer to as de factor rationing—don't admit that patient that your knowledge of the DRG system tells you is going to cost us a cost overrun. The little old lady, the poor—what's the word? I'm sorry. In other words, just those people that these whole programs were designed to protect are going to be the first to suffer.

Senator **Durenberger**. Where is that pressure coming from that you talk about?

Dr. **Primich**. It's a very benign pressure at this point. It is just saying, "Look, doctor, you work in this hospital. It's a nice hospital. We want it to survive. You want to have a place to take your patients." We are faced with a problem where we are being arbitrarily told, and my written testimony—I won't belabor the point—documents exactly what is happening.

In other words, in New Jersey, the ratesetting commission has made a farce of the appeals process. They have told us, for all intent and purposes, that appeals will be unfavorably considered, and you had better grab what you can and forget it.

Senator **Durenberger**. I am curious. Is the pressure coming from hospitals? That seems to be the implication. Or is it coming from the ratesetting process?

Dr. **Primich**. No; the ratesetting process puts the hospital at risk. The hospital that I worked at had worked out a budget on the basis of the projections at the time. The ratesetting commission arbitrarily came along and, after the rating had been essentially set, not only for that hospital, but for all the others, knocked down 2 percent on the basis of, by their reasoning, what the hospitals had been overpaid the previous year. The year that they are telling us about how much the hospitals made.

Now, on this basis, the budgets that were already set have to be reduced. In other words, the budget was already in operation. This was in January of this year that the rates came out. And according to my hospital, we had to cut another $500,000 from the budget that we thought we were operating under.

Now, there were a few things here and there that could be cut that didn't come close to it. Now, how is the hospital going to survive unless the doctors will be cooperative and do these things? And, as I say, right now it is a very soft, very pleasant request.

Senator **Durenberger**. How do you perceive your relationship? Do you work for the hospital, or does the hospital work for you? How should that little old lady that you talked about perceive that relationship?

Dr. **Primich**. The hospital provides certain facilities. The physician, hopefully—and if some changes that are in the works right now don't go through—is the one who makes the determination of diagnosis, treatment, and so on. And, in that sort of structure, we work together. In other words, the medical staff should be responsible for the quality and the caliber of care. And, our own voluntary peer review—

Senator **Durenberger**. The little old lady would be happy to hear you say that, because she doesn't choose her hospital. She chooses you because she likes you and she is used to you and you always give her good advice. So, now she is relying on you to make a choice of hospitalization. Take it from there.

Dr. **Primich**. Yes, sir.

Senator **Durenberger**. The hospital is telling you that the hospital setting is a very meaningful place for you, doctor. You can't really have much of a practice without us. Start early discharge planning or do something else to keep us in business. Is that the implication?

Dr. **Primich**. No; my concern for my patients extend not only to my treatment, but where I would hospitalize them. And, I have chosen to work in hospitals where I felt that these patients had the best of quality care. I personally have long, in the inner workings, opposed many of the things that became factors in cost, such as routine anything. I am a very firm advocate that the physician should have the right to make judgments. He should not be told by the hospital or anyone else that every patient must have a chest-X-ray, every patient must have a certain type of blood test, and so on.

Senator **Durenberger**. I take it, you have been on the losing end of some of those.

Dr. **Primich**. Well, I have been on the losing end of a lot of it, but I have come out on the winning end because now I am being told that everything I said was correct. It was just my poor way of saying it that didn't affect the change. I hope that I have improved my way of saying what I just said to you, Senator.

Senator **Durenberger**. And, I appreciate the response because I think we could spend the morning exploring this, and I would enjoy exploring it with you because you are not here in the same kind of representative capacity as some of these other people. You have dealt with the DRG system and with prospective payment. You obviously see the value in peer review and utilization review and some of the quality review processes as long as they are not overregulatory and deal with the realities.

Can we, as a society, afford to let the hospitals decide what the level of care is, or are we going to get physicians and patients involved in that process?

Is this form of prospective reimbursement the best way to do it? Are there things that we should change in it or add to it?

Last week I raised the question of peer review and utilization review with the Secretary of Health and Human Services. His response, in effect, was that the intermediaries will handle this process, or that the medical liability process—your point No. 3—will handle it. I don't necessarily trust either of these processes to handle quality assurance, and feel fairly strong about adding a peer-review element. But, I don't seem to be able to get a lot of support from the budgeteers around here and, in many cases, from the AMA.

But we really need to hear from physicians about how best to do quality assurance, or, in this case, I think, particularly, quality in conjunction with utilization.

So, maybe Dr. Schenken can respond to that.

Dr. SCHENKEN. Senator, I think the American Medical Association has a consistent record of supporting medical peer review. I think we have differed from time to time, with perhaps you and perhaps others, on the method by which this should be done. But, it is an unbending and consistent record. And, we think, actually, medical peer review and willingness of physicians to participate with this or any other system to try and see if we can make it work, has and will continue to be our policy in the future. I guess what we are concerned with is, we don't feel that the New Jersey experiment reflects in toto the administration's proposal. Therefore, we don't think you can translate the one to the other. And we would like to see how these various DRG's do, in fact, impact.

We think most hospitals and most physicians are going to act in an ethical, cooperative fashion through their peer review. But there are just enough questions about it to cause us to say, "Well, let's try it for a while and maybe we can learn——

Senator DURENBERGER. We haven't got peer review. Would you say that if we are going to do some kind of DRG-based prospective payment system, by all means make sure that there is medical peer review built into the process? Would that be a position of the AMA?

Dr. SCHENKEN. Yes; I would be assured of that.

Senator DURENBERGER. Dr. English.

Dr. ENGLISH. Mr. Chairman, could I just comment on the New Jersey experiment as we have had a view of it from across the river? Because we were, quite frankly, surprised, those of us who practice in hospitals in New York, to read the reports of many of our colleagues in the New Jersey hospitals that were more positive about this system than we would have really imagined they would be from at least our understanding of the way the system might operate. So we invited some of them to come over and visit with us, including some representatives of the hospital association. And we learned something rather interesting that I think the committee ought to take into account as it evaluates that methodology being applied in New Jersey in line with the Secretary's proposal.

They don't feel that the impact of the DRG methodology is yet being felt in New Jersey; that it is going to take a while before the real impact of that methodology is going to be felt; that what has everyone, or many of the hospitals, rather happy about this approach is something totally unrelated to this methodology. The fact that, concurrent with the application of that methodology, the State worked out a way of covering the hospital for the patient that has no insurance of any kind, public or private. And so, that what has made many of the hospitals that were under the greatest financial strain appear to be enthusiastic about this methodology is from a totally different effect to it—a way of working out coverage for unreimbursed patients.

Now, I can understand that in our hospital which is just across the river. We spent, last year, $5 million for the care of patients that we physicians were permitted to admit to the hospital, and put very much at risk, because that is a $5 million deficit for the hospital. There is no way of recovering the cost of providing that care to uncovered patients. So, obviously, if this methodology were confused with the way of taking care of the uncovered patient, we would be ready to endorse it. So, I think it is very important to tease out two very important things that have happened in New Jersey while evaluating that.

Senator **Durenberger**. Thank you. I yield to Senator Baucus.

Senator **Baucus**. Thank you, Mr. Chairman.

Gentlemen, I am a little confused as to the reasons why different sized hospitals charge different amounts for roughly the same services. Perhaps its the end reason the GAO study shows that hospitals with fewer than 100 beds can care for comparable patients. It's 21 percent less than hospitals with 299 beds, and 29 percent less than hospitals with more beds. What's the reason for that variation?

Dr. **Schenken**. Senator, I don't think the entire reason is known. But, if I might refer to my own State of Nebraska, the vast majority of Nebraska hospitals have less than 50 beds, and they are located in cities other than Omaha and Lincoln. And, a wide variety of reasons relative to availability of personnel, general cost of living, and so forth, relate to hospital basic costs not directly related to the medical care. So, I think studying those might reveal additional information. But, at least, in a rural, urban, split State like Nebraska, location and intensity of patients that are treated there has the greatest impact because the bulk of complicated patients are referred either, in our case, to Omaha and Lincoln, or from the northern half of the State up to the University of Minnesota or the Mayo Clinic from our particular location.

Senator **Baucus**. Did the DRG proposal then give a windfall to those hospitals with fewer than 100 beds? DRG-266?

Senator **Durenberger**. Can you think of a better word than "windfall"? [Laughter.]

Dr. **Schenken**. Without responding, Senator, to the term "windfall," in TEFRA there was a proposal that also did that. Perhaps, there would be a way to look at smaller hospitals' problems uniquely. We are concerned, however, that the national rates could, in fact, do that. And we are not alone. A representative of the CBO, in front of Ways and Means, made the same observation on small hospitals just 2 days ago.

Senator BAUCUS. How might this committee modify DRG-based prospective reimbursement proposals to take account of those differences?

Dr. SCHENKEN. Well, the American Medical Association hasn't looked at that specifically. We supported exclusion of the smaller institutions in treating them differently under TEFRA, and would probably do the same until you had a look at how these rates work. It is also possible that the proposals to do regional variations in the DRG rates might also handle that same problem. That would be one of the benefits of experimentation.

Senator BAUCUS. Either of you.

Dr. ENGLISH. Senator, I think you have raised a very important question. And may I attempt two answers to your first question? Using our only hospital as an example, our rates would be higher at St. Vincent's than some of the smaller hospitals. We are just under 1,000 beds.

Part of the reason that our rates are high is because we are very often referred the patients that those other hospitals can't really adequately provide for. The patients that we treat are, for the most part, enormously complicated cases, which, therefore, requires our intensity of care to be greater; our rate is therefore higher. So that, if you look closely enough at the case mix, you will see that comparing our patients with those patients in that small hospital is comparing, in many instances, apples and oranges. It is a different case mix.

But, second, and I think less well understood, is the fact that the rate of our hospital is an all-inclusive rate, which means that the rate of the psychiatric patient includes the cost of caring for the open-heart surgery patient, too. If you teased out the psychiatric rate separately, it would appear to be more competitive even with the smaller hospital.

I think that too often the prospective reimbursement methodologies are simplistic in their approach to those kinds of questions. And, for example, if this methodology were endorsed, let me tell you what the effect could be at a hospital such as ours. The administration would put us under great pressure not to expect, not to accept, such complicated patients because, obviously, they would have a powerful financial incentive to make the case mix at our hospital look much more like that of the smaller hospital.

Senator BAUCUS. Where would they go? Where would those patients go?

Dr. ENGLISH. I think that's an important question for you, sir, and it's an important concern for us. There would be a continuing disincentive to find a way of extruding those patients. And I think that would be very bad.

Senator BAUCUS. Dr. Primich.

Dr. PRIMICH. Well, in order for any of these ideas to really work, you have to, in a sense, individualize all the specific variables that pertain to each hospital. Now the New Jersey program—one of the things that diffused our opposition to it initially was that they were going to take this into consideration. By and large, everyone of the 100 and a few hospitals in New Jersey has individually had its rate set on the basis of that hospital's experience, its essential financial requirement, and so on.

Now, in so doing, it was obvious that the ratesetters would not—or at least it has become obvious—that they couldn't hit the ideal solution. So, the way the process worked is, there was a proposed rate schedule. The process of appeal was going to make it fair. The whole program was inundated with appeals so that literally, as of now, the hospitals that went into this program in 1980—there were 26 of them—they have had final reconciliation for only 6 of those 26 hospitals. That means 20 of those hospitals still do not know what their bottom line was for 1980. And this, of course, absolutely renders the concept of prospective payments in relation to this program as inoperable.

In other words, against now we are constantly—the supposed benefit is that you are going to know what you are going to make in the coming year in time to make your budgetary judgments. This whole system is falling apart. There have been all sorts of excuses. The New Jersey Department of Health has to wait until the Traffic Bureau has their computers free in order to—it's a long sad story.

But the point of it is that it does not work, sir. That's the all-important thing. And, to try to project this to the rest of the country with some concept that this is a very fine operating system that has all sorts of benefits is totally untrue.

Senator BAUCUS. What's your reaction to the proposal to date? Let's assume we pass this bill at the same time, or at about the same time, to also provide for an independent body of physicians, hospital administrators, representatives from a cross section of medical groups that would get the baseline data, if it was available, and analyze what the effects are with respect to reimbursement. This independent body would aid this committee, this Congress, HCFA, the hospitals and physicians, and so forth. What would your reaction to that be? And, could that be a help? We have got to do something. Dr. English said the present system is not the best and he can almost accept anything. I am wondering whether that outside group could make some worthwhile suggestions.

Dr. SCHENKEN. If I understand your question, this would be a very logical step. However, it would be time consuming. Since I have been down here these few days, all I keep hearing about are fast tracks, and greasing the sluice ways, and so on, and a number of statements were made by apparently responsible people who said that there really isn't much time to think about this; let's do it first, and we will think about it later. Now, I don't think that should be done that way. In other words, there are many things that can be done along the way to try to——

Senator BAUCUS. Maybe there's a mid-position where we can do something. The point is for us to move and to keep moving along at a reasonable rate, but, at the same time, have the assistance. I'm looking at the aid that the National Commission of Social Security provided to this Congress. They were successful in putting together some solutions, and I think probably by-and-large those recommendations will be enacted fairly quickly. That's not the best model solution, but at least perhaps is a guide.

Dr. ENGLISH. Senator, I think that is an enormously creative idea because it could conceivably address this kind of question. I know that when we, as physicians, bring you the issue of quality of care, that that has sometimes been interpreted as our reluctance to approach new methodologies that really can have us, as well as the hospital, participating in cost effectiveness. I would agree that there is a case for that.

But, let me tell you, there is another case that we understand very well in New York. We are a State that has been on the brink of bankruptcy. You are worrying about the future bankruptcy of medicare. We were on the brink of bankruptcy. We see what that can do to the regulatory apparatus under that kind of pressure when the bottom line is that money must be saved. What that can do, Senator, to the quality of care in a hospital, what that can do to the exclusion of patients who need care, what that does to the death of patients and to the closure of hospitals, is something we know a great deal about because the pressures of that regulatory apparatus, regardless of what the balance considerations ought to be, are driven in a direction that we understand, and we have experienced.

If there were an outside group that could somehow both legitimatize the cost-effective concerns, but could monitor that quality of care in the way that you, as well as all of us, have to be concerned about, that would be a value. For example, we are puzzled that the Secretary would apply this methodology—32,000 beds in general hospitals—where there has been no study, by his own admission, of its applicability. We believe that is an example of this overpowering drive related to the fiscal dilemma. We understand it. But we think that there has got to be some kind of a monitor against that kind of application that will have unintended but very real effects that New York and other regulated States have already experienced. Some way of balancing that, that this committee might consider, I think we would welcome it.

Senator BAUCUS. Dr. Schenken.

Dr. SCHENKEN. Senator, without prolonging this, good minds getting together and working on a problem is always helpful except to the extent that it might delay the solution of the problem accidentally. And, while we, ourselves, are doing just the same thing right now—trying to get together and think this out—before it should be done, and we figure we might as well get on with it, it has got to be tried in its entirety and find out by trying how it works. And, the New Jersey experiment has so many other features that are unrelated to the administration's or other proposals that we don't think they are related. So, sure, we would support any sort of approach that's a high-level approach to try to think these out. But certainly would not be any more supportive of that without making sure that it would work and not to the detriment of patient care.

Senator BAUCUS. The key question for such a group would be that its actions have credibility, whether it is an outside group or whether it's an AMA group or professional group or whatever.

Dr. SCHENKEN. Yes, credibility, of course, but in the end, as far as patient care, it's also accuracy of their conclusions.

Senator BAUCUS. That's better than credibility. Thank you all very much.

Senator Durenberger. Yes, thank you. I have one or two comments. In the absence of Senator Bradley, I hate to say this, but I don't know that the Secretary is using New Jersey as our model. I mean, obviously, they spent a lot of time looking at the pros and cons of the New Jersey system, and we had testimony last summer about it. And so, all of us have tried to find the flaws with that system, and we appreciate Dr. Primich with his experience and Dr. English with his proximity adding a dimension to it.

The other observation that I always bristle at a little bit, because I am guilty of it like everyone else, is when we talk about making policy and cutting costs at the same time. I am a hospital trustee and have been for a number of years, and I am very proud of my hospital. But, I can also recall my experiences over that period of time with respect to who really runs the hospital. Over the last recess, I spent some time reading a variety of reviews of the hospital system in America, way back to the early roots. It's a fascinating study, and it comes to one conclusion. And that is that you and I are today in the grips of a system that costs an awful lot of money. But there aren't any easy ways to change it. Hospital administrators are trying their darndest to contain costs, and so are trustees and physicians and politicians. We have built, into this system, a large commitment to bricks and mortar and a whole lot of other things in the name of quality health care. Some part of that increased cost reflects inflation and third-party payment systems. And some part of it reflects the failures of the regulatory processes that now have us by the throat. And, we are trying to find a way out of this mess. That is about as fair a statement as I can make about where we all come from in trying to find a solution for the little old ladies as well as on the taxpayers. The pressure for cost control is also felt by the institutional provider system with its obligations to investors, and its obligations to communities.

Where we look to physicians for leadership is, in telling us how we can address the cost issue and the quality-of-care issue differently, because the way we have been doing it is a failure. One way or the other it isn't working out.

And so, if we seem impatient, it's only because we see, for every billion dollar increase in the cost of sick care in this country, that means somebody is going without a home, or going without a meal, or going without some education, or something. That's the condition this country is in today. We all are part of that driving force that is depriving people of other things that they need. We have to look to all of you for answers because you are the people that are making the decisions for the little old ladies and everybody else about institutional care.

Thank you all very much for your testimony.

Dr. English. Thank you, sir.

Senator Durenberger. Our next witness will be Lucille Joel. I hope I pronounced that correctly. It is Dr. Lucille Joel who is president of the New Jersey Nurses Association from Trenton, N.J.

I wish Bradley would get here. We have got all these New Jersey folks testifying.

Dr. Joel is testifying on behalf of the American Nurses Association. What did I do to your name today?

Dr. Joel. It's Joel.

Senator DURENBERGER. Joel.

Dr. JOEL. Right.

Senator DURENBERGER. Close to Christmas.

STATEMENT OF DR. LUCILLE JOEL, PRESIDENT, NEW JERSEY NURSES ASSOCIATION, TRENTON, N.J., ON BEHALF OF THE AMERICAN NURSES ASSOCIATION, KANSAS CITY, MO.

Dr. JOEL. I thank you for the opportunity to be here today. I'm Lucille Joel. I'm president of the New Jersey State Nurses Association. And I am testifying on behalf of the American Nurses Association.

I am also professor and director of clinical affairs at Rutgers College of Nursing in New Jersey.

I bring an additional dimension to my testimony since I have served in an advisory capacity for the past 4 years to the nursing portion of the DRG project in the State of New Jersey.

Mr. Chairman, I would like to highlight some of our concerns, the ANA's concerns, about the administration's proposal for prospective payment for medicare, and make several recommendations regarding this legislation.

We agree with the premise underlying the administration's plan that until recently under the current retrospective cost reimbursement systems hospitals had no incentive to deliver services in a cost efficient manner. We believe that prospective payment is a promising alternative. However, there are other important concerns that must be addressed in designing a major revision in the medicare program if cost efficiency is to be encouraged while quality maintained. Both the prospective payment system in general and the DRG mechanisms specifically have implications for the quality and cost efficiency of health care not only in the medicare program but for the entire national health delivery system.

We seem to constantly create payment mechanisms and then attempt to mold our health care delivery system to fit them. It would seem desirable to create an efficient health care system; then determine the reimbursement mechanisms or at least prepare the system to receive them.

And I think Senator Baucus alluded to this before. That there can be preliminary phase-in steps in a program.

Although neither the issues nor options are simple, we feel that there are three essential principles to which the solutions must adhere. Within these principles, there are proposed solutions which policy can take, which will maintain the integrity of the medicare program

No. 1, the medicare program must be preserved as a system which provides the elderly and disabled with appropriate, high quality and cost effective protection against the expenses associated with poor health, rather than a system which increases the burden of these vulnerable populations. The health of our aged and disabled citizens is vital to the overall well-being of our Nation. We cannot afford, nor is it desirable, to erode the quality of health care we provide these people. In fact, it is crucial that solutions concentrate on exploring options to expand and improve the benefits and coverage of the medicare program. Cost efficiencies can be realized through accessing reimbursement to ultimate settings for delivery of care, and to midlevel health providers that are not currently reimbursable.

No. 2, the changes must insure the future financial integrity of the medicare program, as an insurance program whose major beneficiaries are patients. Changes in the financing of the medicare program must address the fact that the health care delivery system which has been fostered under the medicare program is provider dominated. The sick must not be allowed to suffer to benefit any payer, provider, or vendor of health care.

No. 3, although changes to the medicare program should not be used to accomplish all of the Nation's health cost containment goals, any changes made must be within the context of the entire national health care delivery system. Such a system must include all payers, providers, and vendors. Otherwise, changes will merely shift costs from the medicare program to other sources, not affecting the overwhelming problem of escalating national health expenditures, and presenting a real danger of creating a three-tiered system of health care delivery. Internally to any one system or model of reimbursement or part of it, solutions must take into account all of the major sources of cost escalation, including pharmaceuticals and medical supply industries, as well as the actual health care providers.

It is against these standards that the administration's proposals or any health cost containment system should be evaluated. Both a prospective payment system in general and the DRG mechanism specifically have many implications for the quality and cost efficiency of health care, not only in the medicare program, but for the entire national health delivery system.

A major shortcoming of the proposal for prospective payments is that it applies only to medicare. We believe that it is absolutely essential that any cost containment mechanism apply to all payers. Without uniformity among payers, the system is open to a tremendous amount of gamesmanship to shift costs, rather than encouraging improved management efficiency. A system which applies only to medicare provides greater incentives for shifting costs than for controlling costs. Moreover, the lack of uniformity, coupled with cutbacks in medicaid, will result in the development of the three classes of health care I alluded to earlier—the private, the public, and the medicare system.

I realize that this is not—there is no simplistic solution because you are here dealing with issues of State versus Federal prerogative. So we are drawing your attention to the fact, though, that until the rules of the game are the same for all of the players, there will be inequities and cost shifting which ultimately is going to hurt the sick.

It is also crucial that a prospective payment system apply to all providers, not just hospitals. Any incentives for cost efficiency must apply also to physicians who make by far the majority of health care decisions. And I would add these prospective principles should apply to nursing should nursing be costed out eventually separately on a patient specific basis.

The administration's proposal has failed to provide for an adequate system of professional standards review. And has also failed to develop an enforcement mechanism to assure a certain level of quality care. Without strong Federal deterrents, cost can be expected to continue to spiral with subsequent diminution of patient access to quality services. We maintain that regardless of the method chosen to encourage cost efficiency an effective enforcement mechanism provides the best incentive to providers. It should be added here that the phenomenon of skimming, dumping, revolving door types of syndromes that are noticed with the DRG methodology are eventualities in any system. Once a system is in place, the ways to circumvent and manipulate that system are learned by the people involved in it. So I don't feel these arguments are ones to throw out an entire system, but rather to address and to be sensitive up front to.

The DRG mechanism, itself, has many limitations. The DRG methodology was ostensibly selected by HCFA because of the relative success of the study in New Jersey. However, the administration's proposal ignores major factors pertinent to that New Jersey experience. The most obvious factor in that experience being that the New Jersey program was part of a statewide rate setting program which applied to all payers. It's a total model. It's not just DRG.

In essence, DRG methodology is only one commonality between the administration's proposal and the New Jersey program.

I would like to focus on that for a moment. The diversity of the population and the situation in New Jersey, the demographics and density of population, the environmental characteristics provide a unique testing ground for policy, which there are plans for application to a broader population or an extended geographic area. The case in point today are the DRG's, the rate setting, reimbursement methodology.

We have experienced some success in New Jersey. I would refute some earlier speakers. There has been success. And we hope for greater cost efficiencies as the program is refined within the State. The success that we have experienced—and I am not prepared to say whether that success is minimal or maximal, and I think external review should be considered to try to identify the nature and the extent of the success and the successful pieces within the system. But the success required support to the providers and to the industry as they learned that cost efficiency and quality care are not mutually exclusive.

And the departure point for success and cooperation is often to resolve their philosophical arguments. There had to be a tremendous investment in education of medical staff because the physician is the gatekeeper. And the prescriptive prerogatives of the physician are involved in the DRG system.

There had to be a tremendous amount of effort involved in rate blending so that there could be equity from hospital to hospital or beginning equity. The system in New Jersey requires a total model that makes special accommodations for escalating cost of waiver because, indeed, we do have very retrogressive salaries for employees in health institutions in select parts of our State.

The program in New Jersey requires systems of DRG coordination and utilization review to address quality assurance. And efficiency in the appeals mechanism process so that there is a positive cash flow. I am not saying the appeals mechanism is refined at this point, but there is a need to evolve toward that.

Additionally, success in New Jersey is contingent on sophisticated computer technology, and refined and complete information that flows from hospitals. This was not easy to come by, and promises continued growing pains. The New Jersey system is evolving though. And taking pieces and applying them out of context can be treacherous.

Other factors aside from the instrumentation of reimbursement are important to look at if we are going in some way to super impose the New Jersey experience on a national model. New Jersey has also had clinical resources ready to compliment the expected repercussions of a prospective case mix incentive based system. We have home health care and community nursing services that are sophisticated and strong, though they are not adequately reimbursed. And this is another issue to come to task with in a total model.

Our diversity as a nation has been our strength, but when we get to looking at levying rules of gamesmanship on a nation it signals us to proceed cautiously and with flexibility. There are regional differences in practice and resources which may exist and which may well be justified.

Let me comment more on the nature of——

Senator DURENBERGER. How much more?

Dr. JOEL. Not too much more. Let me comment a little more on the nature of the problems that have evolved within New Jersey. Cost-efficient hospitals become characterized by complex case mix, high volume of patients and decreased length of stay. This creates tremendous intensity in nursing resources uses, which are not adequately addressed by the administration's proposal. The need for support and assistance from nursing personnel is an individual determination, and influenced by a whole range of variables that the proposal is not sensitive to. Recognizing these differences and allowing them to be actually costed out can lead to more complete restoration and self-care ability and cost saving on the part of the patient.

The DRG schemer assumes that emergency treatment and elective treatment require equal amounts of resources. This is another inequality. With respect to nursing services, there are allocation statistics pending rate setting in New Jersey which actually, significantly stratify for differences in the admissions status as far as nursing resource use.

Let me say, Mr. Chairman, that we call your attention to the concluding specific recommendations in our written statement. We believe more study and evaluation must be undertaken, not only of DRG's, but other classification systems. And more study is needed on how they will be implemented and interact with State programs.

Second, medicare coverage should be broadened to allow for more comprehensive based in-home and community health care services, and for direct reimbursement to nurses as primary providers. Earlier discharge from hospitals is only desirable if there is sufficient community and home health care capacity to meet the problem. Any changes in medicare to accommodate the increased need for community services should be accompanied by similar cost containment provisions to prevent increased and uncontrolled costs in other areas of the health care system.

The American Nurses Association does have alternate proposals. A recently introduced bill sponsored by Senator Packwood addresses these important goals and provides for community based nursing services, and is an alternate to very costly institutional care and direct access to the consumer to these prerogatives.

I thank you for the opportunity to testify today. And I would be pleased to answer any questions. And I hope I have focused in on those pieces I can best serve as an expert to address.

Senator DURENBERGER. You definitely have.

[The prepared statement of Dr. Lucille Joel follows:]

TESTIMONY

of the

AMERICAN NURSES' ASSOCIATION

The American Nurses' Association is the professional association representing the nation's registered nurses. We are pleased to have this opportunity to present our views on the Administration's prospective payment proposal for Medicare.

The American Nurses' Association is and has been gravely concerned about the rapid escalation in health care costs which threaten not only Medicare, but also the quality and access to care for the entire population. It is clear that policy makers must act to slow this rapid escalation in order to improve both the financial outlook of the Medicare program and the quality of and access to the nation's health care delivery system.

We would like to comment on the Administration's proposal for a hospital prospective payment mechanism for Medicare, based on the Diagnostic Related Groups (DRGs). Under this system, Medicare would establish the hospital payment rates in advance, rather than, as under the current system, paying hospitals for whatever costs they incur in treating patients. The established rates would be based on a patient's diagnosis, using one of 467 DRGs to classify a patient's illness or treatment. All hospitals would be paid the same rate for treating a given diagnosis, although rates would be adjusted for variations in local labor costs. Hospital capital costs would be treated separately and separate provisions would be made for hospitals where costs are higher due to medical education.

We agree with the premise underlying the Administration's proposal that until the enactment of TEFRA (Tax Equity Fiscal Responsibility Act) under the current retrospective cost reimbursement system hospitals had no incentives to deliver services in a cost-efficient manner. Because hospitals are reimbursed for the costs they incur, this method actually rewards excessive costs and inefficiency. We agree, therefore, that in the efforts to control health care costs and improve the Medicare program, it is important to focus on incentives and disincentives for providers.

However, there are many other important concerns which must be addressed in designing such a major revision in the Medicare program if cost-efficiency is to be encouraged while quality is maintained. We would like to address what we believe are essential components of any cost-containment effort, and, thus the factors that must be considered in establisning a prospective payment mechanism. Within this framework, we believe that the Administration's proposals fail to address adequately, many important factors.

It is clear that policy makers must act quickly to resolve both the benefits and financing dilemma facing the Medicare program. Although neither the issues nor options are simple, we feel that there are three essential principles to which the solutions must adhere. Within these principles, there are proposed solutions which policy can take which will maintain the integrity of the Medicare program.

First, the Medicare program must be preserved as a system which provides the elderly and disabled with appropriate, high quality and cost effective protection against the expenses associated with poor health, rather than a system which increases the burden of these vulnerable populations. The health of our aged and disabled citizens is vital to the overall well-being of our nation. We cannot afford, nor is it desirable, to erode the quality of health care we provide these people. In fact, it is crucial that solutions concentrate on exploring options to expand and improve the benefits and coverage of the Medicare program.

Second, the changes must ensure the future financial integrity of the Medicare program, as an insurance program whose major beneficiaries are patient populations. Changes in the financing of the Medicare program must address the fact that the health care delivery system which has been fostered under the Medicare program, is provider-dominated.

Third, although changes to the Medicare program should not be used to accomplish all of the nation's health cost-containment goals, any changes made must be within the context of the entire national health delivery system. *Such a system must include all payors, all providers and all vendors*. Otherwise, changes will merely shift costs from the Medicare program to other sources, not affecting the overwhelming problem of escalating national health expenditures, and presenting a real danger of creating a three-tiered system of health care delivery. Solutions must take into account all of the major sources of cost escalation, including pharmaceutical and medical supply industries, as well as the actual health care providers.

THE ADMINISTRATION PROPOSAL

It is against these standards that the Administration's proposals or any health cost-containment system should be evaluated. Both a prospective payment system, in general, and the DRG mechanism, specifically, have many implications for the quality and cost efficiency of health care, not only in the Medicare program but for the entire national health delivery system. The Administration's proposals, however, fail to take into account the many crucial factors which affect both the cost-effectiveness and quality of health care. Furthermore, we are concerned that the system which will be implemented in a major, national program, is patterned after a state experiment for which the experience is limited. Moreover, the Administration's proposal will come on top of already major changes recently implemented in the Medicare program, the effects of which are not yet known.

A major shortcoming of the Administration's proposal for prospective payment is that it applies only to Medicare. We believe that it is absolutely essential that any cost-containment mechanism apply to all payors. Without uniformity among payors, the system is open to a tremendous amount of gamesmanship to shift costs, rather than encouraging improved management efficiency. A system which applies only to Medicare provides greater incentives for shifting costs than for controlling costs. Moreover, the lack of uniformity, coupled with cutbacks in Medicaid, will result in the development of three classes of health care: private, public and Medicare. It is also crucial that a prospective payment system apply to all providers, not just hospitals. Any incentives for cost-efficiency must apply also to physicians who make, by far, the majority of health care decisions, and, therefore, are crucial to the success of any cost-containment efforts.

The Administration's proposal does not provide any credible safeguards against skimming, dumping and manipulation of patient mix. Clearly, this will lead to a tremendous burden on the public and voluntary non-profit hospitals, particularly, which will end up assuming the responsibility for treating the most ill, and, therefore, most costly patients.

The Administration's proposal has failed to provide for an adequate system of professional standards review, and has also failed to develop an enforcement mechanism to ensure a certain level of quality care. When cost containment requirements are placed on the health care industry, the need for quality assurance, peer review, appropriate use and distribution of resources increases.

Without strong federal deterrents, costs can be expected to continue to spiral with subsequent diminution of patient access to quality services. We maintain, that regardless of the method chosen to encourage cost-efficiency, an effective enforcement mechanism provides the best incentive to providers.

The DRG mechanism, itself, has many limitations. It is not, as seems to be assumed, a panacea and when used as the sole categorization for determining payment, ignores may important variables.

The DRG methodology was obstensibly selected by HCFA because of the relative success of the study program in New Jersey. However, the Administration's proposal ignores major factors pertinent to the New Jersey experience. The most obvious factor being that the New Jersey program was part of a statewide rate setting program which applied to all payors. In addition New Jersey has in place several mechanisms to prevent skimming and dumping. In essence the DRG methodology is the only commonality between the Administration's proposal and the New Jersey program.

The DRG proposal provides no way to measure qualitive differences in care and, therefore, may reward providers for substandard care and may penalize those who provide appropriate high quality care instead of penalizing high-cost inefficiency. The Adminstration's proposal, by averaging the cost of care, would pay all providers the same whether certain services were provided, whether adequate staffing levels are maintained, and for care which may be substandard. The DRG proposal, by not providing any definition of the product which Medicare is purchasing, is leaving a tremendous amount of discretion to hospitals to determine what Medicare will pay for, subject to enormous variations and regrettably, but most assurdly, abuse.

The DRG mechanism does not adequately reflect the intensity and variety of necessary support and assistance required by a particular patient and family or by the grouping. The need for support and assistance from nursing personnel is an individual determination that is influenced by a variety of factors including the patient's level of knowledge about the diagnosis and the impact on his or her life-style and future capabilities, the capacity of the patient and family to participate in the care-giving process, and the presence of disabling conditions associated with the aging process, prior incidences of disease, debilitation or trauma, and the patient/family's cultural background. Even in some states where measurement of the relative intensity of services have been attempted, the result has been a retrospective determination of the costs of services provided but not of the care and services needed by the patient or the grouping.

Use of the DRG inappropriately assumes that medicine and nursing have established proven methods of treatment of all medical diagnoses and combinations of diagnoses. The DRG mechanism is insensitive to the amount of time that may be needed to determine the proper treatment approach for an individual when physiological imbalance is complex, severe, and unstable. To relegate these individuals to the "outlier" group is to be blinded to the true costs of care.

There are, of course, "easier" cases requiring relatively less service. Unfortunately, most hospitals do not have the mixture of easy and difficult so as to be equitably treated by an "average".

The cost-savings in the DRG proposal is based, partially, on the premise that length-of-stay will be reduced. As length of stay in the hospital decreases and as more medical and surgical treatments are performed outside the hospital, the numbers of patients who can be described as having complex, severe, and unstable conditions in the hospital will increase. The "outlier" group may become more the norm than the exception in future years and the prospective payment mechanism must be able to accommodate this. Moreover, where length-of-stay is already relatively short, such as, for example, in the Pacific

Northwest, this mechanism may force hospitals to put patients at risk by premature discharge.

The DRG schema assumes that emergency treatment and elective treatment require equal amounts of resources; with respect to the use of nursing services, the patient and family need for support and assistance varies widely with this variable. Additionally, the DRG approach assumes that individuals within any grouping with the same diagnosis present themselves for treatment under the same conditions. Whether the treatment that is required is elective will influence the condition of the patient but other factors, such as the patient's nutritional status and hydration level, are important determiners to response to treatment as well as to the use of resources.

Because of the use of the number of procedures in calculating payments, the DRG mechanism favors surgical treatment over non-surgical treatment of a condition. Such a bias in payment will do nothing to curtail the number of surgical procedures performed and will do less to encourage research and continued clinical exploration for non-surgical solutions to health problems. We do not wish to suggest that all surgery is unnecessary but rather we wish to stress that surgical intervention is but one of a variety of modes of treatment for many conditions. To encourage surgical interventions through a payment mechanism is unwise.

In summary, the DRG mechanism does little to recognize the reality of care and services provided by professional nurses to hospitalized patients or to recognize the varying needs and conditions of the patients. Although the DRG mechanism may appear as a manageable, logical approach for payment, the problems cited earlier will diminish any savings or cost control anticipated. We urge your consideration of other classification schema that include the patient's and family's need for support and assistance as well as the overall condition of the patient for determining the payment to hospitals for care and services rendered; such classifications do exist.

CONCLUSIONS

In light of these serious concerns we urge the committee to consider the following recommendations in the development of legislation encompassing a prospective payment mechanism.

- An evaluation of the effect of reimbursement changes enacted under TEFRA should be initiated to determine the impact of those changes on public and voluntary non-profit hospitals, patient care services, utilization of services, patient care staffing and, if possible, the quality of care.
- A rate-setting mechanish should be developed which would extend to all providers, professional as well as institutional.
- The prospective payment system should include mechanisms which would effectively contain costs for capital equipment and other vendor costs.
- Calculation of DRGs in second and subsequent years? Does averaging include non-reimbursable excessive costs for a given DRG?
- In states where rate setting programs apply to all payors, the federal Medicare prospective payment program should accept the rate established by the state for beneficiaries regardless of classification system used. In addition, the federal government should undertake a study to evaluate the effectiveness of the arrangement.
- Hospital classification should allow for legitimate justifiable differences such as geographic areas, size of hospital, type of institution, i.e. university

medical center, community hospital etc., union contracts, as well as case mix.

- In as much as the DRG mechanism is still in an experimental stage, early legislation should address implementation of DRG's and other classification systems on a trial basis. Consideration should be given to the severity of illness index such as the one under study at John Hopkins University and the relative intensity measures (RIMs) which are being evaluated in New Jersey. Other mechanisms for prospective payment such as per diem, per capita rates should also be evaluated. There is no strong evidence to support the DRG methodology as being superior to other classification mechanisms.

- In recognition of the fact that the availability of nursing services in a hospital is the major reason why patients are admitted for care, any future system for Medicare payment must include the recogniton of the need for and the cost of the services of professional nurses through a classification and accounting system. The present system hides nursing services under the general rubric of routine operating costs. This has the effect of making reductions in quality of care under the guise of overall cost-efficiency. Nursing services are placed in a highly vulnerable position and are a prime target for the budget cutting ax.

- Medicare coverage should be broadened to allow for more comprehensive community based and in home, health services. Earlier discharge from hospitals or even non-admission to hospitals are only desirable results if sufficient outpatient clinics and community and/or home care service capacities exist.

In addition any changes made in Medicare to accommodate the increased need for community services should be accompanied by similar cost containment provisions to prevent increased and uncontrolled costs in other areas of the health care delivery system. A recently introduced bill (S410), addresses these important goals and provides for community based nursing services.

- Finally, it is imperative that an effective enforcement mechanism be implemented to ensure adherence to certain standards for the delivery of health care services and to curb the natural tendency to skim, dump, and to manipulate patient mix and admissions.

We thank you for this opportunity to present our views and will be happy to work with the Committee in its further deliberations on this matter.

Senator **Durenberger**. I have six questions that I am going to submit to you and ask you to respond to in writing. And I will defer at this time to Senator Baucus if he has any questions.

Senator **Baucus**. First, could you expand briefly on cost shifting, which you mentioned? That is, you are worried about the potential cost shifting. What do you mean?

Dr. **Joel**. Well, I think that came out of two points in my statement. First of all, what I am saying is that any model, any total package you put into place, can be manipulated eventually. All you have to do is live with it long enough and you will find how the system can be worked to maximize the benefits to you.

Senator **Baucus**. Where do you think cost will be shifted?

Dr. **Joel**. What I am saying is that there will be a tendency for hospitals to be most fiscally sound, catering to complex case mixes. And impacting—like decreasing length of stay. And these are the internal mechanics I think you have to be aware of. And you have seen it through some of the reports of dumping and skimming. Is this what you are alluding to?

Senator **Baucus**. Whatever you have in the back of your mind that you mean by cost shifting.

Ms. **Jones**. I think the biggest issue that we are dealing with cost shifting—when you are dealing with only one payer such as medicare, I think there would be a tendency to shift the cost immediately to the other payers, the other private payers. And this would be the biggest area. But I think there would also be a tendency to shift costs to other areas that perhaps may not be covered under the DRG itself—outpatient costs. Why not in the area of your capital equipment and all those costs.

Senator **Baucus**. Would there be a tendency for hospitals in perhaps larger hospitals to reduce staff; the number of nurses? Would that be a possibility?

Ms. **Jones**. It's a possibility.

Dr. **Joel**. It's a possibility because nursing has not traditionally been costed out on the intensity on a patient specific basis. And until—what has happened in our State is that as the length of stay has become compressed, there has been a sandwich effect, and the intensity of nursing per patient increases. In other words, every bed is filled with a patient that has very intense nursing needs.

The management information does not currently exist to prove some of these points because nursing is not costed out on a patient specific basis so you are right. There could be shifting of costs from the nursing budget internally. There could be a battlefield established within the hospital.

And the other comment was that unless the bad debt, the capital outlay, the other types of things are equitably shared by payer groups, there is going to be shifting among groups.

Senator **Baucus**. Dr. Joel one theme that ran through your statement is absent of any standards, health care standards. Can you come up with any? Can you recommend any health care standards or any of the approaches to standards that we might consider?

Dr. **Joel**. The American Nurses Association is ready to address peer review for nursing, and has developed and promulgated standards of practice for its own professional field. Through those payers where we are currently reimburseable, we are addressing peer review. We do feel that the profession should police their own ranks. And should be the major driving force in utilization review where their profession controls those prerogatives.

Senator BAUCUS. Should we leave it entirely to professions as to what happens to hospitals in order to save—discharges a patient early?

Dr. JOEL. Well, I think there is a two-pronged system. There are the professional prerogatives, and then there are the management prerogatives in the cost efficiency, the managerial pieces of hospitals. And within our State, the hospitals that have been most effective operating within the system have very efficient programs of internal utilization review and DRG coordination. And they have found there can be a very excellent working relationship between nursing, who is responsible on a 24 hour basis, and is there to monitor and observe the patient, and the physician provider, and there can be a meeting of minds as to discharge status, and the appropriateness of discharge conditions.

Senator BAUCUS. What's your view of PSROs? Is that a good idea?

Dr. JOEL. Yes, but it has to have peace in it. And it has to be enforceable. And you have to really address the quality care issue; not just minimum standards.

Senator BAUCUS. I noticed in your conclusions on page 8 "the prospective payment system should include mechanisms which would effectively contain costs for capital equipment and other vendor costs."

I point that out because I noticed that our next witness will be the president of the Health Industry Manufacturers Association. What would you be telling him? That is, what should he be ready for? What do you mean by that statement?

Dr. JOEL. What we have seen happen in our State is that there has been an attempt, as the system is blended in, and it's blended through a State standard in a hospital or an agency standard, and it is eased in. But there is an attempt to certify the budget in the various departmental areas to avoid cost subsidization, et cetera. You will find out that certain departments are not cost efficient because there is not enough use for their services within one hospital.

What I am getting to is that you are going to have to look at more consolidation of services between agencies. And this does impact equipment, some of the very high cost equipment. You are going to have to look at some of the corporate diversification, and unbundling mechanisms which are the good sense of the use of the word. That services will have to be shared. That the more complex types of cases may have to be regionalized. And this may be nursing complexity as well as medical complexity.

To give you a very simple explanation, the use of generic versus brand name drugs is another cost saving technique. Also we are going to have to get down to the cheapest way as far as equipment, supplies and manpower utilization.

Senator BAUCUS. But when you say "contain costs for capital equipment and other vendor costs," generally those costs are high.

Are they charging too much or are you saying they are underutilized? What are you saying?

Dr. **Joel**. All right. I don't have the data to say whether they are too costly or not, but that we have to find the most cost-efficient way of getting the technology to people. And we have to look at the cheapest way to provide supplies, and to provide this type of technology. Does that make sense?

Senator **Baucus**. I understand we have got to get the cheapest way. No one can disagree with that. But I am wondering if you have any particular examples or whether you feel strongly that capital costs and other vendor costs are, in fact, too high. That is, reduction in capital and other vendor costs without sacrificing all——

Ms. **Jones**. Our recent issues of Value Line have indicated that the—like the pharmaceutical industries, the hospital supply industry are really labeled as recession proof. And that there is a fair amount of money in that area. And I think we have to look very carefully on where money is being made within the health care system, and who is being made to bear the burden of it, which is the patient.

Senator **Baucus**. Well, unfortunately we have both a lot of questions and not much time left.

Dr. **Joel**. All right. We would be pleased if you would submit any questions to us additionally.

Senator **Durenberger**. Thank you very much for your testimony.

Our next witness will be Mr. Harold O. Buzzell, president, Health Industry Manufacturers Association, Washington, D.C. He has been patiently sitting out there since 9:30.

Harold, welcome. We have read your statement. It will be made part of the record. You can do with it as you please for the next 10 minutes.

STATEMENT OF HAROLD O. BUZZELL, PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION, WASHINGTON, D.C.

Mr. **Buzzell**. Mr. Chairman, I have a very short statement. I will be done before the yellow light comes on, to say nothing about the red light.

Without hopefully being gratuitous, I did want to take the opportunity before I started, to applaud the committee itself—as well as Andy Jacobs' committee in the House and the administration, especially former Secretary Schweiker and Dr. Rubin—because you are, in fact, onto a very exciting and promising concept. And to address it so timely in this session of Congress, I think, is very laudable.

We come here today to support the concept of prospective payment. I'm pleased in having read the testimony of two dozen other groups, that generally you are getting support for the concept. We have heard a couple of exceptions this morning, but the trend certainly seems to be one of support.

We support it as manufacturers, recognizing that it is going to have an impact on our markets for our products in some cases. And that impact will be negative. There will be a dampening of demand for certain medical products because the concept is one that is based on prospective reimbursement in which it behooves a hospital to use only those products it absolutely has to use to treat a patient.

You asked a question earlier about capital equipment. This concept, in fact, does place a great deal of emphasis on making sure that the equipment is cost effective, that it saves labor, and that it is generally not over priced for a very simple reason. And that is that we live in a very competitive environment.

I have spent considerable time, myself, in New Jersey. They are turning to Japanese suppliers for catheters, in some cases, because they are cheaper. CAT scanners, a favorite topic of everyone in this town, is a product that is sold in a competitive environment. There is an Israeli company that is competing with my members now. So the concept itself, I think, lends itself to improved competition.

Like everyone else, we've got a few reservations about the Secretary's proposal; particularly, in the area of medical technology. The New Jersey system—as you have heard witnesses say—is not working as well as it should in terms of the appeals process. And particularly because they are not doing a good job in New Jersey of technology assessments. And they say they are not. So you may need something from the offices of the National Institute of Health with some independence, to do the job.

Let me list several principles that we believe are critical to a prospective payment system.

First, prospective payment should stimulate provider productivity. The New Jersey system does that. And your plan will have to do that.

Second, the payment system should have a moderating and a predictable effect on medicare spending. That is happening in New Jersey. Certain people are disturbed because it is predictable in the sense that it is coming down. But it is a moderating and predictable effect.

Third, the system should assure quality health care and access to that care. Everyone concedes that so far, in New Jersey and in Maryland and other States using this kind of mechanism, there doesn't appear to be any erosion of quality of care. But it is a consideration. And I can respect the position of the American Medical Association in its concern over the quality of care because, in spite of all of medicare's problems, the cost-based system still is a system that is providing access to quality care. That needs to be preserved.

Fourth, the payment should reflect the differing characteristics of medicare beneficiaries. An appendectomy for a 75-year old Senator is not as cheap as an appendectomy for a younger person. They do, in fact, in New Jersey take those items into account. They adjust the DRGs for health characteristics. They adjust them for sex, which I am not totally clear as to why. And they also adjust them for age. That will have to be done.

Fifth, the plan in the long-term should, I think, apply to all health care providers. You know, it's a tough issue because it does open up the possibility of cost shifting. In that regard, I think history tells us that you don't have to worry too much about significant cost shifting. Blue Cross/Blue Shield, either directly or indirectly, is purchasing care for 100 million subscribers. I don't believe that Blue Cross/Blue Shield and other health insurance providers are going to permit rates that are substantially higher than the rates under the DRG system for the medicare beneficiaries. But nevertheless at some point in history, this may have to be an all-payer system.

And I think equally important, my last principle, my last point, is that it clearly will have to be extended to other sites beyond hospitals at some point in history. That's a trend in this Nation, as you know. I'm amused that many of us here in Washington forget that competition has already come to the health care system hospitals in New Jersey and in other places are finding it increasingly difficult to maintain patient loads. So at some point in time, the DRG—the prospective system—will have to be extended to all sites.

That is, in summary, our statement. Two concerns I will leave you with. One, again, is the medical technology issue. We are fortunate in this country to have the best health care system in the world. It's, in part, due to the products we develop. It's also due to the nurses, the doctors, and the hospitals. And you are going to have to have a technology assessment mechanism that works, and is timely.

And then, finally, there is a lot to be done in terms of the medical recordkeeping systems that exist in the hospitals. That's been one of the big challenges in New Jersey. But as I said earlier, I have been up there. They are doing an excellent job in most of their hospitals with computer-based accounting systems. And that is going to have to happen on a nationwide basis.

I thank you very much.

Senator **DURENBERGER**. Thank you very much for that very thorough analysis and that look ahead at other things that we need to keep our eyes on in terms of policy changes.

[The prepared statement of Mr. Buzzell follows:]

STATEMENT OF

HAROLD O. BUZZELL

PRESIDENT

HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Mr. Chairman and Members of the Subcommittee:

My name is Harold O. Buzzell. I am President of the Health Industry Manufacturers Association (HIMA), a trade association representing 285 manufacturers of health care products.

HIMA commends this Subcommittee for its prompt consideration of a key issue -- Medicare prospective payment. Over the last several months, prospective payment has been the subject of careful attention by the Health Care Economics Committee of the HIMA Board. We appreciate this opportunity to share our thoughts with you today.

* * * *

After these hearings, you will have heard a broad range of views on prospective payment. Two points I want to stress about HIMA's testimony are these:

First, our industry supports the concept of Medicare prospective payment to replace the program's current hospital reimbursement system.

Second, we support, in general, the prospective payment plan submitted to Congress by the Department of Health and Human Services. We have concerns, however, about some aspects of the plan.

The Concept of
Medicare Prospective Payment

Need for Reform of
the Current System

The current Medicare reimbursement system is seriously flawed. By paying costs already incurred, the system dispenses penalties to the productive and prosperity to the inefficient. These perverse incentives fuel escalating program costs -- costs estimated at more than $57 billion for the current fiscal year.

Though the Tax Equity and Fiscal Responsibility Act (TEFRA) made significant changes in Medicare, the program remains flawed because hospital payments are still tied to costs incurred.

Principles for a Workable
Prospective Payment System

To correct flaws in the current reimbursement system, HIMA supports enactment of a Medicare prospective payment plan. We believe prospective payment should embrace six principles:

1. Prospective Payment Should Stimulate Provider Productivity.

The system should contain incentives to encourage providers to reduce costs through increased productivity. The incentives should be positive -- they should reward efficiency.

2. The Payment System Should Have a Moderating and Predictable Effect on Medicare Spending.

Our economy cannot support continued rapid growth in Medicare spending. Medicare should be restructured to moderate spending growth and assure that spending is predictable.

3. The System Should Assure Quality Health Care and Access to That Care.

Despite its flaws, current Medicare reimbursement assures access to high quality care for the elderly and disabled. Prospective payment should encourage efficiency without sacrificing quality or access. Of special significance to HIMA is quality care made possible by advances in technology. Prospective payment should not stifle the research that produces new technologies, which, in turn, enhance the quality of health care.

4. Prospective Payment Should Reflect the Differing Characteristics of Medicare Beneficiaries.

Prospective payment rates should reflect characteristics (such as age, sex, and health status) of the beneficiary populations whose care the system finances. Without considering these differences, the system might place undue burdens on beneficiaries with exceptional health care needs and providers that serve those beneficiaries.

5. Prospective Payment, in the Long Term, Should Apply to All Health Care Providers.

Prospective payment should promote efficiency in the health care system as a whole -- not just in hospital inpatient settings. To encourage system-wide efficiency, prospective payment should eventually apply to all providers.

6. Prospective Payment Should Avoid Undue Regulation.

The system should promote efficiency through financial incentives, not heavy-handed regulatory controls.

The Department's Prospective Payment Proposal

HIMA commends the Department for its prospective payment proposal. If enacted, the proposal would make encouraging changes in Medicare.

Under the proposal, hospitals would be rewarded for shortening inpatient stays, restraining costs of labor and supplies, and reducing use of ancillary services. Improving productivity in these ways should moderate growth in Medicare spending.

While HIMA supports the Department's proposal in general, we have concerns about some aspects of it. In particular, we are concerned about the proposal's potential effects on new technology.

1. The Proposal Could Jeopardize Quality Health Care by Inhibiting Development of New Technologies.

The proposal would establish fixed hospital payments that would differ according to Diagnosis Related Groups (DRGs). In computing the payment level for a given DRG, the Department would consider costs of caring for patients in that DRG, including costs associated with health care technologies. Since historical cost data would be used to compute the DRG rate, that rate would reflect use of established technologies, not new ones. The DRG rate would be like a snapshot in time -- a snapshop depicting yesterday's technologies, not today's.

In the proposal, the Department sketches procedures for adjusting DRGs to reflect technological advances. HIMA believes that unless these procedures are carefully structured, the proposal could inhibit much of the research that fuels technological development. This could limit the availability of new diagnostics and therapies.

To adjust DRGs properly, the Department will need substantial amounts of information on technologies. The Department will need to determine early in the life of a technology whether it will be effective and, if so, for which cases. Answering those questions will require understanding not only of the technology's costs at the time a patient is admitted to a hospital (the proposal's frame of reference), but also the technology's benefits to the patient and Medicare over time. If a technology eliminates a future hospital stay for a patient, for example, the Department should consider this benefit in its adjustment process.

HIMA offers its cooperation to the Subcommittee and the Department in developing the adjustments process. Our goal is to insure that this process will allow technology to continue to contribute to quality health care for Medicare beneficiaries.

2. Over Time, the Department's Data Should Be Improved.

Through DRG's, the proposal would fix Medicare payments per case. One important purpose for case-mix adjusted rates, according to the proposal, is "to match explicitly patient benefits with the costs of services provided to Medicare beneficiaries."

The Department's pricing methodology would use pre-TEFRA hospital accounting data to construct case prices. This data reflects hospital management and resource allocation practices intended to maximize reimbursement of costs. In many cases, these data reflect inter-departmental cross subsidies or charging schemes, which could cause faulty case prices under the Department's DRG system.

There are also other flaws in the Department's data. According to the National Academy of Sciences, for example, more than 30 percent of the Medicare cases the Department recorded in 1977 and 1980 contained errors as to primary diagnosis.

The combination of these flaws may produce case prices that cannot be economically matched by well-managed hospitals. To compensate for these potential problems, we urge that the Department's data be improved over time through the DRG adjustments process. Again, HIMA offers its cooperation.

Conclusion

HIMA reiterates its support for prospective payment and its support, in general, for the Department's proposal. We would be happy to work with the Subcommittee and the Department to perfect the proposal so it brings fiscal responsibility to Medicare without inhibiting development of new technologies.

Senator **Durenberger**. This afternoon we are going to hear more about payer systems. We are going to hear from the Health Insurance Association of America. And they are going to tell us that we have got to have an all-payer system in order to keep a level playing field. What they really mean is that Blue Cross is already getting a break and an all-payer approach forces more equal competition. I think as you point out, we are not doomed to failure, because we don't adopt DRG's as an all-payer system nationwide, are we?

Mr. **Buzzell**. I don't think so. I think experience tells us that the medicare system in terms of a cost reimbursement system, became the model for the private health insurance system. And I'm hopeful and confident that if you launch a prospective system based on DRG's for the medicare population, the rest of us will follow suit very quickly. It may require legislation later on. I'm not sure.

But I guess our conclusion is that you have got one heck of a challenge in terms of launching a nationwide prospective DRG system for just the medicare beneficiaries without trying to make this thing all encompassing at this point in history.

Senator **Durenberger**. On page 6 of your statement you make a recommendation that the Department should determine whether new technology is cost effective, and make appropriate adjustments in the payment system to accommodate that new treatment. How realistic is it to assume that such determinations can be made? And how early on in the use of new technology?

Mr. **Buzzell**. Well, it's realistic, but it would probably be difficult. I would like to use the example of the CAT scanner again. You have a chicken and egg problem, and it's a very understandable one. By the time you have determined that body scans are, in fact, good candidates for reimbursement because they do, in fact, cut out unnecessary exploratory surgery and things of that nature, you are well into the evolution of the product. So there's a difficult problem for the manufacturer in terms of investing those research dollars, and in terms of going operational with the product—a very expensive proposition, as you know.

The experience with HCFA, going back 3 or 4 years, was relatively good. And I was there representing the manufacturers in terms of dealing with those very issues when we started out reimbursing for head scans, and then eventually we started reimbursing for body scans. And that was a decision that was made within the Government, but on the basis of relatively objective testimony from radiologists and many others and on an awful lot of cost-effectiveness studies.

So it's a challenge, but it has been with us anyway under the cost reimbursement system.

Now, again, in terms of our industry, we recognize that even though we support this concept, it is going to have some negative impacts on us because, under the cost reimbursement system, the rule has been to reimburse. And the exception has been to challenge the reimbursement. Again, referring to your own state, one of our members is a major manufacturer of pacemakers. And currently, programable pacemakers are being reimbursed. Dual chamber pacemakers are being reimbursed. Under the DRG concept, those sorts of products will come under more scrutiny because they will be getting *x* numbers of dollars for an implant.

But it is certainly doable. And, as I say, you have that challenge with you now anyway as part of your responsibility for the trust fund. The Government has that responsibility.

Senator DURENBERGER. Well, we are obviously concerned that we don't—I suppose you could use the pacemaker as an example—want to adopt a DRG based on current technology and the costs of current technology, only to find that a more expensive technology can further reduce the cost of operation. We don't want to make this system so bureaucratic that it gets in the way of better technology that might be more expensive up front, but save money in the long term.

Mr. BUZZELL. Yes. Medical technology is dynamic. And a simple example is cataract operations. They are running negative variances in New Jersey in cataracts simply because the DRG was set back in a time when the tendency was to do the operation without putting in a lens. Now they are putting in these intraocular lenses, and they are not covered under the DRG.

But the fact is the physician still controls the practice of medicine in the State of New Jersey. And he is putting in the lens regardless of the problem that the hospital encounters. I made reference to the fact, though, that under your system you are going to have to have a better appeal mechanism than they have in New Jersey. They acknowledge themselves that their basic approach to the appeals process is to tell the hospital that that is their problem. Out of their $66 million budget at Morristown they have to find the money to buy that new technology. At some point in time that is going to be a problem as that system matures.

But it is dynamic and it is something you do have to take into account, I think, in drafting your legislation. It happens to be an area where we would like very much to help you because we have a very direct stake in the field.

Senator DURENBERGER. Thank you very much. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. I'm a little confused as to why an all-payer system would reduce competition among insurance companies. It just seems to me that with a little more competition we might get some of the fat, if there is fat.

Mr. BUZZELL. Well, it doesn't have to. That will depend very much on a provision that you will have to put in your legislation, in our judgment. In our judgment, a hospital ought to be able to charge less, if it wishes, than the DRG rate.

And I will give you a real good example. Again, I refer to Minnesota because——

Senator BAUCUS. You think the hospital is going to do that?

Mr. BUZZELL. Sure. And you are going to hear testimony from the Group Health Association of America that wants to preserve its leverage in terms of competition. It purchases health care—generally in terms of hospitalization—cheaper than many of the rest of us simply because of their leverage. They are high volume and things of that nature. And, again, in Minnesota the prepaid health plans are able to compete—I guess is the best word—or cause the hospitals to compete for their business.

Senator DURENBERGER. Would you yield on that point?

Senator BAUCUS. Sure.

Senator **Durenberger**. Does the current legislation as proposed prohibit the kind of negotiation you just referred to? This is a very good point to make.

Mr. **Buzzell**. First of all, it isn't legislation as you know. It's a prospective plan. And I don't believe it addresses it. I could be wrong. But I don't think it addresses it specifically. I think it is just a silent consideration.

Now I will say this. The New Jersey system does not. And that is a problem in New Jersey. The price is the price is the price. And that would appear to be a little silly, frankly.

Senator **Durenberger**. You think the bill should allow hospitals to negotiate rates?

Mr. **Buzzell**. Yes.

A simple appendectomy and simple pneumonia in New Jersey is going for about $910. And it doesn't make any difference what it costs the hospital to provide that. So if I went there, for example, representing 20,000 subscribers—and as I say, one of your following witnesses will speak to this point—and if I could demonstrate that because you won't have any bad debts on my suppliers and so forth, that you ought to charge us less for that. That doesn't happen now in New Jersey.

Senator **Baucus**. You say your association generally supports the concept. Are you worried that in these times of very high deficits that OMB might make a political decision in allocating so many dollars with respect to reimbursement rather than paying as much attention as it should to the quality of health care?

Mr. **Buzzell**. No; I'm not worried about it. Frankly, they are doing it anyway in terms of TEFRA and what they have done here in the last couple of years. But, no, I am not.

Senator **Baucus**. Why are you not worried?

Mr. **Buzzell**. Well, under the——

Senator **Baucus**. Aren't you worried that the next David Stockman might come along and be very, very Draconian with his budget scalpel?

Mr. **Buzzell**. Well, I think you have an excellent checks and balances system in terms of the Senate and the House. And I think that to the extent they were excessive, that would be corrected by the U.S. Senate. I was in HEW when we attempted not to spend appropriations back in 1970. We were accused of impounding funds, and were successfully sued, and started spending the money. This body has a way of correcting that type of excessiveness if it occurs.

There's another observation that is terribly important to make. As health care costs continue to climb at the rate of 15 to 20 percent per year, you will, in fact—as the chairman alluded to a few moments ago—have an erosion of quality of care because you are going to see a dampening of access to care. Unemployed workers in this country now whose health benefits have run out have a problem with quality of care. And it is probably attributable to the fact that the cost of care has gotten to be exorbitant.

Senator **Baucus**. Thank you very much.

Senator **Durenberger**. Thank you very much, Mr. Buzzell. We appreciate it.

The next witness is Mr. Thomas Pyle, president of the Harvard Community Health Plan, Boston, Mass.; and vice president, Group

Health Association of America, on behalf of the Group Health Association of America.

STATEMENT OF THOMAS PYLE, PRESIDENT, HARVARD COMMUNITY HEALTH PLAN, BOSTON MASS.; AND VICE PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, WASHINGTON, D.C.

Mr. PYLE. Thank you, Mr. Chairman.

I have submitted written testimony which includes some technical issues. I would just like to make some brief comments about general aspects of DRG's and make a comment or two about the specific impact upon HMO's.

Senator DURENBERGER. Your testimony will be made part of the record. I mean your advance testimony.

Mr. PYLE. Thank you.

[The prepared statement of Mr. Pyle follows:]

STATEMENT OF

THOMAS PYLE

VICE PRESIDENT
GROUP HEALTH ASSOCIATION OF AMERICA, INC.
and
PRESIDENT
HARVARD COMMUNITY HEALTH PLAN

BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

ON
THE ADMINISTRATION'S MEDICARE HOSPITAL
PROSPECTIVE PAYMENT PROPOSAL

FEBRUARY 17, 1983

SUMMARY

- GHAA commends the Administration for recognizing prospectively determined payment as an important element in its strategy to contain Medicare costs and for its efforts to fashion its prospective hospital reimbursement proposal based upon diagnosis related groups (DRGs) in a manner which does not disadvantage HMOs.
- Before commenting further on the implications for HMOs of the Administration's new payment system, it is important to point out that in general DRG-based and other similar hospital reimbursement systems create problems for HMOs. A fundamental incompatibility exists between internal HMO mechanisms to promote the cost effective delivery of care and an external system intended to promote cost effectiveness generally. The resulting conflict neutralizes and even reverses HMO incentives for the efficient use of health care resources.
- A DRG-based hospital reimbursement system for Medicare would not have a negative impact upon HMOs with cost-based Medicare contracts. HMOs with risk-based contracts would be directly affected; however the extent of the detrimental impact is unclear. Many HMOs may well hesitate to enter into risk-based Medicare contracts without first being able to realistically assess the impact of DRG-based hospital reimbursement.
- Because of the significant percentage of hospital costs nationwide which are paid by Medicare, the use of DRG-based reimbursement may encourage, if not induce, states and perhaps some individual hospitals to move to all payor DRG-based rates. In any movement toward such all payor systems consideration should be given to preserving the negotiating flexitility needed for HMOs to take maximum advantage of their existing incentives to reduce utilization and contain costs.

Mr. Chairman and members of the Subcommittee, I am Thomas Pyle, Vice President of Group Health Association of America (GHAA) and Chairman of the association's Legislative Policy Committee. I am also President of the Harvard Community Health Plan. Group Health Association of America represents over 100 prepaid group practice health plans, a majority of the group and staff model health maintenance organizations (HMOs) in the nation. Our member plans serve approximately 8 million enrollees, 80% of the total national HMO enrollment. The Harvard Community Health Plan is a twelve year old staff model HMO serving in excess of 120,000 enrollees in Boston, Massachusetts.

GHAA welcomes the opportunity to comment on the Administration's Medicare hospital prospective payment proposal. Payment for health services provided by HMOs has always been on a predetermined, prospective basis, a major contributing factor to our ability to provide high quality, cost-effective health services to our enrolled members. Both the Congress and the Department of Health and Human Services have already made a commitment to prospective reimbursement for HMOs, in particular, through enactment and progress toward implementation of a new Medicare payment mechanism for HMOs contained in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, Section 114, P.L. 97-248). We commend Secretary Schweiker and the Administration for their recognition of prospectively determined payment as an important element in their strategy to contain Medicare costs.

Before commenting further on the implications for HMOs of the Administration's new payment system, it is important to point out that in general DRG-based and other similar hospital reimbursement systems create problems for HMOs. A fundamental incompatibility exists between internal HMO mechanisms to promote the cost effective delivery of care and an external system intended to promote cost effectiveness generally. The resulting conflict neutralizes and even reverses HMO incentives for the efficient use of health care resources.

During the development of its hospital prospective payment proposal based upon diagnosis related groups (DRGs), the Department of Health and Human Services has made serious efforts to fashion a workable provision for HMOs. While we have not seen the legislative proposal and therefore cannot comment on it, we are aware that approaches are being considered which would permit needed flexibility for HMOs, and we are grateful for the time and attention the Department has given to addressing the special characteristics of HMOs.

The clearest example of HMO difficulties with DRG-based rate setting is found in the New Jersey all payer system. There, HMOs and other providers must pay rates based upon DRGs reflecting average community patterns of providing health care services. Where the usual length of stay of HMO members is shorter than the community average, where the HMO performs pre-admission diagnostic testing in its own outpatient facilities that would otherwise be performed in a hospital, and where HMO patterns of practice otherwise differ from those in the community, the HMO must through the DRG rate pay for services not used. The unfortunate result is that while the new incentives may promote greater efficiency in the health care community at large, HMO disciplines are weakened. This, in turn, can lead to a gradual increase in the HMO's length of stay experience, as well as a loss in the HMO's ability to exert cost control pressures on their participating hospitals. In fact, Touche Ross and Company, auditors for the Rutgers Community Health Plan, recommended to the plan in a management letter last year:

> (Under DRGs) if pre- or post-hospitalization services are currently being provided at the Health Center, and it is anticipated that a patient will not fall outside the trim points, the Plan may want to have such services performed in the hospital rather than the Health Center, thus resulting in a shifting of costs to the hospital.

While the Touche Ross recommendations might be in the HMO's best short-term economic interest, the advice would lead to a shift in services to more costly hospital facilities, clearly counter to HMO principles of operation and to the objective of containing costs in the health care system overall. Absent legislative recognition of the incompatibility of DRG's with accepted HMO practices, Medicare will face the same problem as New Jersey's HMOs, because it will be required to pay for services not rendered or rendered at a higher cost in an inpatient setting.

HMOs are now reimbursed by Medicare in several ways, and the impact of a DRG-based reimbursement system for hospitals depends upon the contracting method used. Those HMOs contracting on a cost-basis under section 1833 of the Social Security Act are reimbursed for Part B services only, and therefore will be little affected.

Section 1876 of the Social Security Act contains a cost-based reimbursement option under which HMOs provide both Part A and Part B Medicare services to enrolled Medicare beneficiaries. The HMO can elect to be reimbursed for Part A services and in turn to make payment to the hospital or can avoid processing hospital reimbursement claims by electing to have these claims paid through the Medicare fiscal intermediary. All HMOs now contracting on a cost-basis under section 1876 have elected to use the fiscal intermediary. Under this option, the HMO would be unaffected by any change in hospital payment rates and the fiscal intermediary would make DRG-based payments to the hospital directly. Reimbursement to the HMO would continue for Part B services on a cost-basis.

Section 1876 of the Social Security Act now also contains the new prospective risk-based reimbursement option enacted in TEFRA. This amendment has generated a great deal of interest among HMOs, and our major concern about DRGs arises in connection with the implementation of this provision. The new payment mechanism provides for reimbursement to an HMO prospectively at 95% of the cost in the non-HMO sector of providing Medicare Part A and Part B services to a population similar in composition to that expected to enroll in the HMO (95% of the adjusted average per capita cost or AAPCC). The HMO must provide the Part A and Part B services at its adjusted community rate (ACR), its usual premium adjusted for the Medicare population. Any difference between the HMO's adjusted rate and the 95% Medicare payment, the "savings", must be passed on to the HMO's enrolled Medicare beneficiaries in the form of increased benefits and/or reduced cost sharing.

Under a DRG-based hospital payment system new uncertainties would be introduced into the operation of this HMO reimbursement formula and particularly the amount of savings which might be generated. Once the HMO receives reimbursement at 95% of the AAPCC, the HMO must negotiate its own rates with hospitals. An HMO may not have the bargaining power to negotiate rates as favorable as those resulting from the Medicare discount, and therefore the HMO may have to pay more for hospital services than the Medicare reimbursement levels. The HMO competes on the basis of its ability to deliver quality care in a more cost effective manner than the predominant fee-for-service sector, but the Medicare discount reflects budgetary decisions to reduce payments rather than increased efficiency. While it is common for the HMO to achieve shorter lengths of stay and lower admission rates than the average in the fee-for-sector, these and other results of HMO patterns of practice are not sufficient to put the HMO on an equal footing with the Medicare discount. The result would be a higher adjusted community rate and a smaller amount of savings generated to be passed on to the HMO's Medicare members. If the HMO is permitted to elect to use the Medicare fiscal intermediary for Part A reimbursement, the problem is minimized.

In summary, a DRG-based hospital reimbursement system for Medicare would not have a direct impact upon HMOs with cost-based Medicare contracts unless they operate their own hospitals, in which case the HMO hospitals would be reimbursed in the same manner as all other hospitals. HMOs with risk-based Medicare contracts would be directly affected by the new payment system; however, the extent of any detrimental impact is unclear. Many HMOs may well hesitate to enter into risk-based Medicare contracts without first being able to realistically assess the impact of DRG-based hospital reimbursement.

HMOs are also concerned about the impact of all payor DRG-based hospital payment systems. Because of the significant percentage of hospital costs nationwide which are paid by Medicare, the use of DRG-based reimbursement may encourage, if not induce, states and perhaps some individual hospitals to move to all payor DRG-based rates. The Department of Health and Human Services has already indicated it would look favorably upon applications for state waivers where the all payor systems proposed are compatible with the proposed Medicare reimbursement system.

DRG-based or similar per case all payor systems present serious difficulties for HMOs. While prospective payment is basic to HMO budgeting methods and cost containment strategies, per case reimbursement based upon community norms undercuts rather than support HMO incentives for the efficient use of health care resources.

HMOs have developed a variety of creative arrangements with hospitals which are beneficial to both hospitals and HMOs. In negotiating with hospitals, HMOs can take advantage of the volume of predictable business they can bring to the institution; prompt payment terms; reductions in bad debts resulting from comprehensiveness of coverage (i.e., no payments to collect from the patient) and guarantees of eligibility; and the benefit of progressive HMO efforts to reduce stays and contain costs such as pre-admission diagnostic testing and early discharge programs.

HMOs (those that do not own their own hospitals) employ various methods to reimburse participating hospitals, depending in part on the above factors. They may pay itemized charges or discounted charges; more typically they pay a more predictable and cost-based all-inclusive per diem rate; some HMOs contract with hospitals to pay for a given number of beds, whether fully utilized or not, providing the institution with guaranteed "occupancy" in consideration for a preferred rate; still other HMOs reimburse hospitals on a capitation basis, providing greater predictability of costs to the HMO and revenues to the hospital.

Regardless of the specific contractual arrangements, HMOs and hospitals cooperate in efforts to share services and optimize the utilization of resources. These can include arrangements to facilitate appropriate treatment of patients who present themselves in emergency rooms; hospitals' agreements to accept the HMOs' pre-admission testing, utilization review and early discharge programs; and sharing of costly diagnostic and treatment services.

In any movement towards all payor per case reimbursement systems, consideration should be given to preserving the negotiating flexibility needed for HMOs to continue to take maximum advantage of their existing incentives to reduce hospital utilization and contain costs. It would be unwise to disadvantage the organizations which are currently achieving many of the cost containment goals which the rate setting systems are designed to promote.

In conclusion, HMOs remain a singular model of innovation and reform in an otherwise cost-reimbursement oriented health care system. We commend the Administration's efforts to treat HMOs equitably under their hospital prospective payment proposal. We urge that any new incentives injected into the system at large be crafted to recognize the difference between conventional modes of health care delivery and the demonstrated effectiveness of HMOs in providing high quality care through comprehensive prepaid direct service delivery systems.

We look forward to working with the Subcommittee as the Adminstration's legislative proposal for DRG-based prospective Medicare hospital reimbursement is sent to the Congress and consideration of Medicare prospective payment systems continues.

Mr. PYLE. First, having read a good deal of what has been written about DRG's recently, I would like to note that they do not constitute prospective reimbursement, but rather prospective pricing, or as it is called in most of the rest of our economy "pricing." It's not a capitation system, nor is there significant risk assumption involved. It is still piecework payment. What is different is that we have picked out a new piece.

I don't say this negatively but rather in just an attempt to clear up what I think have been some confusing attributes given to this new way of doing things.

The DRG is another form of analog, which is really what all pricing is. In fact, in the early 1970's with some of my colleagues at the Boston Controlling Group under HEW contract we wrote a thing called "Reimbursing Hospitals," and we rather elegantly laid out all of the different kinds of analogs that one might use for reimbursment of which this was one.

The other difference between DRG's and the current system is, that they are not cost based. DRG's really go more toward being a price, unlike the current system where the analog of lab tests and days is used to allocate costs.

There is, unfortunately, a problem with all analogs as opposed to true cost, if there is such a thing, type systems, and that is that they invite game playing. What this system will do is develop a new game at which the people in the industry will become quite sophisticated eventually. One really has to evaluate the current game against the new game.

I think it is also worth noting that the current system has a good deal of shifting going on in it. It appears to have become part of medicare policy, and I expect that kind of shifting will go on under a new system. There is also the problem in the current system of technology assessment. Technology as it relates to health care appears to me a good deal like Xerox machines—about 20 percent of what comes out of them is darn useful, and the other 80 percent tends to be recipes and various things that are very helpful to the people who work in a place. I think a lot of technology ends up being that way, but, with that 20 percent being very useful and very important. The problem is knowing which is which without a lot of controls.

I come to the conclusion then, because of all the current problems and the game playing that is possible under any kind of analog system, that administering such a new system will require a good deal of judgment, not just a formula. I think one question one has to be willing to consider in creating such a system is whether it is possible under the legislation to create the kind of judgment that will allow this system to function well? It will not function well by formula.

I think, as you have noted this morning and as Senator Dole has noted, you gentlemen in the Congress really have a very big problem because most of the health care industry today does not believe it can reduce costs, and people who don't believe—and I sincerely believe that statement—who don't believe they can reduce costs, won't. They will cut service, and they will put their energy into fighting whatever system you develop. Ultimately, until we get to the point where physicians become concerned with managerial issues and patients begin to understand that their selection decisions create costs, we will continue to have difficulties. I think that is part of the challenge in administering any new system.

One of the advantages of this system, if one is not attempting to reduce next year's budget, is that more relevant cost comparisons between institutions will be possible, including eventually the isolation of the cost of teaching and research, and this permits the asking of questions.

What we are talking about is a system that will have a longer term payoff, not a short-term payoff.

Let me just turn for a moment to the problems of HMO's, because any payer, who really, assumes risk for the cost of care, any provider who assumes risk for the cost of care, has a different kind of relationship to this kind of system. What this system does is standardize hospital pricing in an area where HMO's, are consistently and systematically lower than standard. In other words, we use less hospital days per diagnosis in general.

Therefore, this system standardizes, from our point of view, on the wrong variable. If we were talking not just about HMO's and not just about DRG's, we could generalize what I am saying to say that any kind of standardized reimbursement system is going to inhibit innovation and other ways of reducing costs, rather than just reducing the particular cost developed by the hospital. It will, in effect, reduce competition in our health care system.

We saw what standardized cars did for Detroit, and I would hate to see standardized pricing do the same thing to our health care costs.

I see this as a worthy experiment. I think it needs flexible administration. I do not believe we should put our eggs in the peer-review basket. If I may speak rather directly about that, I have just come from 2 days of reviewing the bonus recommendations for our physician managers for last year, 24 individuals. In the below-average year, I found out we had 17 people who were above average and seven who were at average, and that is in a structured system where people have learned how to be managers and have had a couple of years of management training. I do not think the health care system is capable of really discriminating peer review, yet, and, I don't think you can hang the financial future of the country on that peg at the moment.

In closing, I would just recommend that in any system, if it develops as an all-payer system—and I think that Mr. Buzzell's comments in that regard are quite perceptive—that we should forcefully exempt from any standardized or analog rates all providers, including HMO's who accept full financial risk for the total cost of care. I think we should preserve the idea that the individual willing seller, willing buyer, can negotiate something that will be at least as good as something that could be designed by a regulator.

Thank you very much.

Senator DURENBERGER. Thank you, Tom, very much. It was very well done, as always. You made the observation that providers don't believe that costs can be contained. I guess I basically agree but would add that it's probably true in any industry. As I understand your testimony, you raised the possibility that providers must respond by cutting services. Perhaps they would respond by adding other kinds of services to broaden their revenue base. Hospitals, for example, could go into some other health-related business related to their basic line. Just add a whole bunch of services, and use that as a way to balance revenue sources. I would assume that, if this is possible that makes the judgment problem that you alerted us to with regard to DRG as somewhat more difficult to get around. I wonder if you would just generally comment on that.

Mr. PYLE. I haven't thought very much about the regulatory aspects of the issue you are raising. I have a view that most people who go into other businesses usually do it because they assume that the problems in a business they don't understand can't be as big as the problems in one that they do. And, generally, the need to earn a return on equity and to borrow money and pay back the lenders is such that I know of no examples of organizations which end up supporting a basic business, which isn't successful in a full economic sense, by going into some new business.

Senator DURENBERGER. I will give you a dozen examples then and you can react to them. Go ahead.

Mr. PYLE. I would like to see that, because, in a sense, if that is the answer, I think we could probably create an endowment for the hospitals in the country.

Senator DURENBERGER. It's called tax-exempt bond financing and other breaks we provide for hospitals but not for other kinds of businesses. I don't mean by that comment that I want to disparage tax-exempt bond financing, but it is going on out there. Wouldn't you agree?

Mr. PYLE. I'm not aware of instances in which that is being done in a way that is supporting hospitals who aren't making enough money to cover their costs in delivering health care. I am not including in that the donated dollars over the years from people who have left their fortunes to hospitals.

Senator **Durenberger**. Let me ask you another question. I can't let your statement on peer review stand without exploring it a little bit. What is the comparability between evaluating performance-base compensation in an HMO and peer review? Why did you use that as an example of why peer review should not be relied on?

Mr. **Pyle**. I used it as an example of the difficulty inherent in peer review. First of all, reviewing peers is very uncomfortable. I think we can all recall an experience of trying to review in a public way or in a private way, but directly, the performance of colleagues, and it's not very comfortable when you do it.

I think it is less comfortable in medicine because it is not a part of the tradition at all. People are really not accustomed to it. It has not occurred in the past. Our tradition has been more in solo practice than in groups. As we now look to this industry to provide that kind of review, without giving it a structure to force it in that direction—and I don't think a national goal represents a structure. I think it represents what our national goal is—I think it would be very difficult to do.

I make the analogy to my own tightly structured organization to say that if it is tough to do it there; then it is even tougher to do it in the more abstract way that I have heard it described this morning.

Senator **Durenberger**. Let's get off the quality or performance based compensation aspects and deal with something that I would assume is an essential part of an HMO, and that is utilization. Certainly peer review takes place in a utilization sense all the time in an HMO or you wouldn't be able to survive. Right?

Mr. **Pyle**. I would have to disagree with you about that. I think that most of the HMO's create a structure which provides a set of incentives so that people practice in a different way. It is not dominated by review.

Senator **Durenberger**. But there's review built into that structure. It may not be formalized as peer review, but you have a group of professionals coming together to practice in a certain way and make decisions about utilization. They have to do that in order to be better than the other guy who does it on a fee-for-service basis.

Mr. **Pyle**. I think if you are using review in the broadest sense of bringing into the practice colleagues with like values and of providing a lot of facilitating mechanisms to practice in a particular way, then, yes, review does function. But that's a very different setting from a fee-for-service solo or small group kind of practice setting. So I think it comes back to the original point that most of the world isn't like that at the moment.

Senator **Durenberger**. All right. Senator Bradley.

Senator **Bradley**. Thank you, Mr. Chairman.

If we start writing the legislation on DRG's, what kind of flexibility do you think we ought to put in that legislation to assure healthy HMO's?

Mr. **Pyle**. To assure healthy HMO's?

Senator **Bradley**. Yes.

Mr. **Pyle**. I think that you should exempt HMO's and other providers who assume financial risk from the DRG system.

Senator BRADLEY. Total exemption then?

Mr. PYLE. Total exemption for those who assume financial risk so that they can negotiate with the hospital on whatever basis. For example, we have our own hospital. We have five other hospitals with major relationships, and about four others with less important relationships. I think we have about 10 different ways of paying those hospitals at the moment, depending on the particular needs of each of the institutions.

Senator BRADLEY. So, therefore, you would be for exemption; not for reduced DRG's?

Mr. PYLE. I would be for exemption, yes.

Senator BRADLEY. Well, if we went not for exemption but for reduced DRG's, what do you think the HMO would have to prove in order to get that reduced DRG? Have to prove economic benefit?

Mr. PYLE. Well, given the kind of creature that an HMO is, a marketplace creature, and the kind of relationships possible between a hospital and an HMO, I don't think the emphasis should be on proof, which is a regulatory concept. I think the emphasis should be on negotiation between those parties—willing seller, willing buyer—and not on a requirement of proof of anything in particular. I would also ask you what should the hospital have to prove to the HMO, which is the other side of that. You see, I don't think a one-sided proof should be required.

Senator BRADLEY. All the hospitals would be under this system where the HMO would be given a special place within the overall DRG system.

Mr. PYLE. No. What I was suggesting is that any provider that assumes full financial risk for care would be exempted.

You see, the strength of the HMO's and the reason that my premiums now are about 20 percent below Blue Cross in Massachusetts is that we have a system, which is a mini-system that we can manage, and we are able to make the most efficient kind of arrangements, and our physicians practice differently and so on. The moment that we become regulated in one piece of that, we no longer have that flexibility.

The other side is that we take a lot of risks in doing that because we take the full risk of the cost of hospital care. I think that should give us a certain privilege, and I think it is something that you really want us to have so that we are constantly trying to innovate.

Senator BRADLEY. Well, let me ask you about the quality. What kind of quality review would you suggest for the DRG system?

Mr. PYLE. In what sense? Of the hospital?

Senator BRADLEY. Yes. The quality to assure that people won't be coming in and out of hospitals very quickly. To assure that the patient is actually being given the adequate treatment; that he is simply not being in and out in order to qualify for the payment. That he is not being kept extra days in the hospital and so forth.

Mr. PYLE. There are really two aspects, I think, of what you are asking me. One is quality from the point of view of the patient. How do we know that there won't be more skimping under the DRG system than there might be under the current system. The other side of it is how do we prevent rip-offs under the DRG system.

Senator BRADLEY. Yes.

Mr. PYLE. I think that preventing rip-offs under the DRG system would probably be somewhat easier than under the current system, but I think that the development of that system is exceedingly complex, I do not feel qualified to comment on it except to say that as a manager I would recommend that goals be set in the legislation with discretion provided for the Secretary to arrange for the necessary reviews to meet these goals. I don't think you can prescribe it in the legislation, because I do not believe we know at the moment how to do that. The only experience we have is in New Jersey, and that is incomplete, as we have heard.

I know that's not a satisfactory answer, but I think that's the best possible at the moment.

Senator BRADLEY. What about for the patient?

Mr. PYLE. From the patient side?

Senator BRADLEY. Yes.

Mr. PYLE. I think the patient will probably rely on the basic values of physicians, which I think are very high on the quality side; somewhat on the malpractice system; and making sure that there is reasonable review within the hospitals.

Senator BRADLEY. Thank you.

Mr. PYLE. Just one final point. One of the things that has been of great interest to me is that the whole field of what I will call software in medical care, which is tools by which to evaluate the way the system works, is grossly underdeveloped. It's one of the areas in which we are trying to do some development, because I think it is impossible for you to set national policy without better information about system performance, and I don't think we have the tools at the moment. It's impossible to get reasonable agreement among groups of people about what constitutes good performance even within one small group of physicians, let alone across a broad system. I think it is tragic that we aren't investing some more money in that software. Something like the Office of Technology Assessment, which has been defunded, is a great loss to the needs that you gentlemen have, I believe.

Senator DURENBERGER. Thank you. Max, do you have any questions?

Senator BAUCUS. No.

Senator DURENBERGER. Thank you very much, Tom, for your testimony.

Mr. PYLE. Thank you.

Senator DURENBERGER. Our next panel consists of Mr. R. R. Kovener, the vice president of Healthcare Financial Management Association, Washington, D.C.; Mr. William H. Ryan, partner in Deloitte Haskins & Sells of New York; and Ms. Sally Simons, American Medical Records Association from Chicago, Ill.

I welcome you all. And if you don't mind proceeding for 5 minutes each in the order that you were introduced we will start with Mr. Kovener.

STATEMENT OF MR. R. R. KOVENER, VICE PRESIDENT, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION, WASHINGTON, D.C.

Mr. KOVENER. Thank you for this opportunity to express our views. I am Ronald Kovener, vice president of the Healthcare Financial Management Association. HFMA has more than 21,000 individual members who are financial managers of health care organizations or are closely associated with those activities. These members are involved in evaluating and implementing the medicare payment system, and are, therefore, very interested in the medicare prospective payment system that has been proposed.

HFMA's "General Guidance Concerning Prospectively Determined Prices" is attached to our written testimony.

HFMA has long recognized the need for and has advocated adoption of a new financial relationship between health care organizations and the Government. We applaud Congress recognition that basic and fundamental change is needed. The Secretary's proposal provides a good framework for discussion, but requires significant refinement to be acceptable. HFMA endorses the Secretary's proposal to determine medicare rates prospectively without provision for retroactive adjustment and to recognize case mix differences through use of a case price for each diagnostic related group.

We do not believe it is appropriate to start abruptly with a system based on national average DRG rates, however. The impact of national average rates on individual hospitals is not known. We do know, however, that care patterns vary across our country for reasons that are not fully understood. We urge an evolutionary approach which initially bases the DRG case price on each hospital's historic, audited and verified medicare data. These prices can gradually be converted to nationally based prices, first for those DRG's with reasonably consistent patterns of resource consumption.

There also must be increased involvement of physicians. A major objective of any change in payment arrangements should be to influence demand for health care services, including modification of practice patterns. Physicians must be involved in the new payment system in a manner consistent with their role as gatekeeper to resource utilization.

There should be an opportunity for patient financial participation. Patient payment is an important way to influence demand for health care services. It can also influence choice of services. Providers must be permitted to assess appropriate charges for additional or higher level care desired by beneficiaries but in excess of that which is paid for with Government funds. It should not be necessary for hospitals to disassociate from the medicare program to assure their fiscal viability or to be able to offer beneficiaries a level of service they desire.

Patient financial participation provides essential financial resources when other economic or political priorities dictate limitations on funding by payers.

As has been voiced by other speakers, the Secretary's proposal to deny providers access to courts to resolve disputes is completely unacceptable. Prompt, impartial, decisive dispute resolution and a process for dealing with exceptions is necessary.

HFMA members are intimately involved in all aspects of preparing the detailed financial reports now required by medicare rules. We recognize the need for a change in focus of detailed financial reports to payers. HFMA urges including all institutionally provided medicare services, including outpatient services, in the new prospective payment system. Systems of controlled charges for outpatient services can provide adequate safeguards for the Government while also providing a more integrated and cost effective system, and significantly reducing paperwork Adoption of an inclusive payment system will greatly reduce the need for detailed reporting.

Payment must be made promptly. The process of updating rates must be impartial and adequate to the continuation of fiscally sound health care services. Arbitrary limits and rates set by edict are not in anyone's long-term interest.

In summary, we would like to reiterate HFMA's recognition of the need for prompt action to develop a new financial relationship between the Government and health care providers. The Secretary's proposal introduces many very desirable concepts, and represents an important step in the right direction. A number of changes are needed, including initial rates based on each institution's historic data, increased physician involvement, opportunity for optional patient financial participation, provision for judicial resolution of disputes, reduced financial reporting burden, compatible rate setting for outpatient and other services, and prompt and impartial updating of rates.

Senator **Durenberger**. Thank you very much.

[The prepared statement of Mr. Kovener follows:]

Statement of the
Healthcare Financial Management Association
before the
Subcommittee on Health
Senate Committee on Finance
February 17, 1983
by
R.R. Kovener, Vice President

Summary of principal points:

- A new financial relationship between healthcare organizations and the government is needed.
- Determination of Medicare rates prospectively without provision for retroactive adjustment is acceptable.
- Recognition of case-mix differences through use of a case price for each diagnostic related grouping is acceptable.
- The Secretary's proposal requires significant refinement, including:
  - -- basing initial rates on each institution's historic data
  - -- increased physician involvement
  - -- opportunity for optional patient financial participation
  - -- provision for judicial resolution of disputes
  - -- reduced financial reporting burden
  - -- compatible rate setting for outpatient and other services
  - -- prompt and impartial updating of rates

I am Ronald Kovener, FHFMA, CAE, Vice President of the Healthcare Financial Management Association. HFMA has more than 21,000 individual members who are financial managers of healthcare providers or who are closely associated with the financial management activities of healthcare providers. These members are involved in evaluating and implementing the Medicare payment system and are, therefore, very interested in the Department of Health and Human Services' proposal for a Medicare prospective payment system for hospitals. HFMA's "General Guidance Concerning Prospectively Determined Prices" is attached to our written testimony and serves as the basis of our testimony today.

HFMA has long recognized the need for, and has advocated adoption of, a new financial relationship between healthcare organizations and the government. In our view, the current system is based on complex and inconsistent rules and restrictive definitions of allowable cost. We do not believe the government is paying a fair share of the cost of serving Medicare patients, particularly costs of capital and charity services. The ever growing body of rules is excessively burdensom. We understand the government's concern that it cannot adequately predict and control its financial obligations under the Medicare program and that the system does not provide adequate incentives for cost effective operations by providers. For these reasons we applaud Congress' recognition that basic and fundamental change is needed. The Secretary's proposal provides a good framework for discussion but requires significant refinement to be acceptable.

It is also important to recognize that attention to new payment arrangements is only one of many steps needed to resolve concern about the cost of health care. The mutual objectives of all parties must be considered -- patients, payors, physicians, providers and the public. Such mutual objectives should encourage cost effective demand and choice consistent with spending priorities of the entire economy, as well as of public funds. Similarly, promises must be in balance with commitment and ability to pay. A greater commitment to adequate funding of the government's promises must be evident in the Secretary's proposal. HFMA members cannot support a system which allows arbitrary payment decisions and at the same time demands that hospitals provide increased services.

HFMA endorses the Secretary's proposal to determine Medicare rates prospectively without provision for retroactive adjustment and to recognize case-mix differences through use of a case price for each diagnostic related grouping. We do not believe it is appropriate to start abruptly with a system based on national average DRG rates, however. The impact of national average rates on individual hospitals is not known. We do know, however, that care patterns vary across our country for reasons not fully understood. We also know that DRG data has many weaknesses such as inadequate recognition of severity, difficulty in handling outliers, in adding new DRGs or reflecting changing care patterns. Also, the fact that DRG data was collected for another purpose effects the relevance of the data to this new purpose. While we support use of the DRG data, we urge an evolutionary approach which initially bases the DRG case price on each hospital's historic, audited and verified Medicare data. These prices can gradually be converted to nationally-based prices, first for those DRGs with reasonably consistent patterns of resource consumption. During this evolutionary process, there must be a commitment to improving the quality and usefulness of the DRG data and this time can also be used to examine additional consumer choice/competition concepts such as vouchers and capitation.

There also must be increased involvement of physicians. A major objective of any change in payment arrangements should be to influence demand for healthcare services including modification of practice patterns. Physicians must be involved in the new payment system in a manner consistent with their role as gatekeeper to resource utilization. Some ideas are included in the "General Guidance..." attached to this written testimony.

There should be an opportunity for patient financial participation. As has been shown by research studies, patient payment is an important way to influence demand for healthcare services without discouraging provision of essential services. It can also influence choice of services for example, it can encourage lower cost ambulatory or home service in preference to inpatient service. In addition, it can improve patients' understanding of services provided and their value; and permit patients to express their preference and priorities. Providers must be permitted to assess appropriate charges for additional or higher level care desired by beneficiaries but in excess of that which is paid for with government funds. It should not be necessary for hospitals to disassociate from the Medicare program to assure their fiscal viability or to be able to offer beneficiaries a level of service they desire. Patient financial participation contributes to accurate reporting to the patient and others of services provided and provides essential financial resources when other economic or political priorities dictate limitations on funding by payors. We stress providing latitude for this provider action recognizing that many, probably most, institutions will not choose this option intially, primarily because of the risk of bad debts and of public relations concerns.

As has been more fully explained by other speakers, the Secretary's proposal to deny providers access to courts to resolve disputes is completely unacceptable. Prompt, impartial, decisive dispute resolution and a process for dealing with exceptions are necessary.

HFMA members are intimately involved in all aspects of preparing the detailed financial reports now required by Medicare rules. We recognize the need for a change in focus of detailed financial reports to payors. The cost of preparing, submitting, receiving, processing, verifying, compiling, using and adjudicating these detailed financial reimbursement reports is very large. Eliminating these costs can contribute to achieving desired reduction in healthcare costs.

HFMA urges inclusion of all institutionally-provided Medicare services, including outpatient services, in the new prospective payment system. Systems of controlled charges can provide adequate safeguards for the government while also providing a more integrated, cost effective system and significantly reducing paperwork. Adoption of an inclusive payment system will greatly reduce the need for detailed reporting.

Rates must be updated no less often than annually and, must recognize inflation, and other other economic and technological changes. Payments must be made promptly. The process for updating rates must be impartial and adequate to the continuation of fiscally sound healthcare services. Arbitrary limits and rates set by edict are not in anyone's long-term interest. Adjustments to compensate for forecasting errors should be promptly included on a prospective basis with consideration of the time cost of money.

While a system meeting the needs of all providers is desirable, there are special circumstances of small and rural providers. Because of these special circumstances, and because the financial impact of these providers is minor, optional participation by these providers in a new system, particularly its early phases, is appropriate.

Provisions for transition from the existing payment system are unclear. We believe a conversion to a DRG rate system based on each hospital's cost data can be made for all facilities on October 1, 1983, or at the start of the next following hospital fiscal year if enabling legislation and regulation work is completed promptly. We urge prompt action toward this goal.

In summary, we would like to reiterate HFMA's recognition of the need for prompt action to develop a new financial relationship between the government and healthcare providers. The Secretary's proposal introduces many very desirable concepts and represents an important step in the right direction. A number of changes are needed including:

-- initial rates based on each institution's historic data
-- increased physician involvement
-- opportunity for optional patient financial participation
-- provision for judicial resolution of disputes
-- reduced financial reporting burden
-- compatible rate setting for outpatient and other services
-- prompt and impartial updating of rates

Additional detail is in our written testimony. We appreciate the opportunity to present these views and are available for discussion and elaboration.

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HFMA
General Guidance Concerning Prospectively Determined Prices

OVERVIEW

In keeping with HFMA's earlier action to establish broad policy guidance concerning "a new financial relationship," this document deals with a specific approach -- prospectively determined prices. HFMA recognizes that prospective prices are but one step needed to resolve concern about the cost of healthcare. Important provisions of this guidance are summarized below.

* 1 **Principles** -- A new financial relationship should be based on mutual objectives, balance the powers of the parties to permit equitable negotiation, match risk with resource control, foster quality, availability, accessibility and innovation, permit alternatives which are mutually supportive, be practical, cost effective and understandable, allow timely management action and be fair.

2 **Competition/Consumer Choice** -- A prospectively determined price system must be compatible with competition/consumer choice principles.

3 **Evolutionary Change** -- Immediate action is necessary which may require equitable short-range systems as part of an evolutionary process.

4 **Alternatives** -- Diversity requires multiple systems, alternatives, and options. Current systems are not necessarily acceptable.

5 **Patient Financial Participation** -- Patient financial participation should influence demand and choice of service, improve understanding, express patient preferences, contribute to accurate billing and provide financial resources. Discretion and flexibility should be permitted.

6 **Scope** -- An integrated system which applies to all levels of service and encourages cost effective choices of service is necessary.

7 **Financial Reporting** -- A change in focus of financial reporting is essential.

8 **Utilization** -- Independent monitoring or control to assure appropriate utilization of service is necessary.

9 **Physician Involvement** -- Physician involvement is essential.

10 **Exceptions and Disputes** -- Prompt, impartial, decisive dispute resolution and a process for dealing with exceptions are necessary.

11 **Updating Payment Rates** -- Annual or more frequent updating of payment rates is essential and should give full recognition to economic, technological, volume and case mix changes.

12 **Third-party Payor Arrangements** -- For payors responsible for a large number of patients, a rate of payment based on a broad average representative of the group is acceptable for most acute care. Other arrangements are needed for other services. A price based on an individual provider's financial requirements with recognition of efficiency achievements is preferable to a rate derived by grouping and comparing providers. Prompt payment is essential.

Adopted on May 28, 1982
Revised on January 10, 1983

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* Corresponds to following sections designated with roman numerals.

I PREFACE/PRINCIPLES

A The predominant current system for paying provider's for healthcare services is based on complex and inconsistent rules and restrictive definitions of allowable incurred cost. Many providers and others believe payors using this system do not bear their fair share of cost, particularly costs of capital and charity services. The system has an ever growing body of rules viewed by many as excessively burdensome. Payors using this system do not feel able to adequately predict and control their financial obligations and do not believe providers have adequate incentives for cost effective operations. These are but a few of the reasons why there is increasing consensus that a new financial relationship is needed.

B While attention to new payment arrangements is needed, this action alone will not resolve healthcare related ethical issues such as the "right to life," the effects of excessive promises or expectations, the mounting competition for resources nor the needs of an aging population. Potential benefits of technological advances, access to capital and essential public and professional education may be interrupted by a change in payment arrangements. Adoption of a new financial relationship is only one of many steps needed to resolve concern about the cost of healthcare.

C General principles for a new financial relationship include:

1. The mutual objectives of all parties must be considered -- patients, payors, physicians, providers and the public. Such mutual objectives should encourage cost effective demand and choice consistent with spending priorities of the entire economy as well as of public funds. Similarly, promises must be in balance with commitment and ability to pay.
2. Payment arrangements should balance the powers of all parties by providing opportunities to exercise direction over what (type, quality and quantity) and where health services are obtained or provided, to obtain or provide financing from multiple sources, to participate or not in selected programs and by other means. In short, all parties need "clout." Rules must allow and encourge latitude of action to achieve objectives. Terms of payment should be determined through a participatory process such as negotiation rather than by edict or mandate of any party.
3. Risk should be matched with opportunity to control use of resources. For example, physicians, payors and patients should be at risk for controlling demand. Providers should be at risk for providing necessary services in a cost effective way.
4. Payment arrangements should foster quality, availability, accessibility and innovation.

5. Payment arrangements should consider local conditions possibly through permitting but not requiring options and alternatives. Payment arrangements to a provider for different types of care or by different payors should be mutually supportive.

6. Payment arrangements should be practical, cost effective and understandable from the perspective of all parties.

7. Payment arrangements and amounts should be reasonably determinable prior to rendering services and should not be subject to retroactive adjustment.

8. Payment arrangements should include provisions for timely, impartial dispute resolution. Exceptional circumstances must be considered.

D There are many alternatives for new financial relationships. Some alternatives give primary attention to the flow of funds from payors, such as capitation or voucher arrangements. While there should be the opportunity for provider's to participate directly in these systems, other arrangements, particularly for implementation in the near future, will likely be used. This "General Guidance..." deals with the flow of funds to providers of services using systems that relate payment to services provided.

E New financial relationships will require new administrative capabilities and systems.

F Industry initiatives to design a new system may result in unfavorable changes if payors pick and choose from the attributes of any proposal and leave only an unacceptable skeleton. Any system will undergo change after initial implementation and, as has been true of Medicare, that change may be undesirable. Even after consideration of these dangers, there is strong sentiment that it is desirable for the industry to take the initiative, and propose reasonably specific guidelines, not merely broad principles. HFMA expects others to devise even more specific proposals and believes this "General Guidance..." will be useful to others in preparing such initiatives and useful to HFMA in evaluating such initiatives.

G This discussion of a new financial relationship is predicated on a sincere desire to serve patients in the best possible way, preserving quality and the propensity to innovate which have been such valuable attributes of the U.S. healthcare system.

II **COMPETITION/CONSUMER CHOICE**

A It is important that a system of prospectively determined prices be consistent with the principles embodied in private sector alternatives of competition/consumer choice. Prospectively determined prices are not inconsistent with these principles and may be an appropriate strategy while systems for implementing competition/consumer choice are devised.

III EVOLUTIONARY CHANGE

A Immediate implementation of new payment systems to replace current arrangements which do not meet the criteria of the guidance is essential. Use of short-range systems which are consistent with these principles while longer range systems are designed and implemented is acceptable. Payment systems should evolve and change over time to minimize disruption and to match current circumstances.

IV ALTERNATIVES

A Providers, patients, payors and geographic areas are diverse. It is unlikely that any single system meeting all these considerations can be designed. Diverse systems, alternatives, options and experiments are desirable to meet varying needs and to encourage creativity and participation. Adequate provider participation in the design and implementation of alternatives is essential.

Current rate control or other payment systems should not automatically be considered acceptable since providers have not had a choice about participating and because current systems may not include the provisions described herein.

B Cautions and Considerations

1. Education of patients is an essential corollary to the provision of alternatives and to encouraging cost effective consumer behavior.
2. Patients in isolated areas have limited opportunity to choose among alternative providers of care which may require special provisions in payment arrangements.
3. Consideration of prompt payment, system simplicity or volume are appropriate in establishing payment rates in various alternatives.

V PATIENT FINANCIAL PARTICIPATION

A Patient financial participation should:

1. influence demand, while not discouraging essential services
2. influence choice of service (for example, encourage lower cost ambulatory or home service in preference to inpatient service)
3. improve understanding of services provided and their value
4. permit patients to express their preferences and priorities
5. contribute to accurate reporting to the patient of services provided

6. provide essential financial resources when other priorities dictate limitations on funding by payors

7. permit discretion and flexibility

B Cautions and Considerations

1. Deductible and coinsurance provisions should be structured in a way which fulfills the above listed objectives. For example, Medicare's present deductible/coinsurance provisions do not adequately fulfill the objectives of patient financial participation particularly when these obligations are insured.

2. Patient financial participation tailored to the type of service provided, may be desirable. For example, in the case of emergency admissions, patient financial participation might be limited to an amount that would be incurred if choice were possible. Greater patient financial participation might be required for selected services to influence choice about obtaining the service or to encourage choice of lower cost alternatives.

3. Location and other factors limit the ability to exercise choices which patient financial participation is intended to foster.

4. Financial participation by patients with limited financial resources requires special attention. Other means will have to be devised to influence demand among these individuals who likely have significant needs for healthcare services.

5. Insurance coverage of the patients' financial participation may reduce or eliminate the desired influence on demand and choice. Appropriate limitations on the insurability of a patient's obligation could strengthen this provision.

6. Some limits on patient financial participation, particularly if insurance coverage is limited, may be appropriate. Annual or lifetime limits might be desirable, but the difficulties of administering such a system may make this impractical. Any such limits should be adjusted regularly to reflect inflation.

7. Provision for advance deposits of expected patient financial participation will contribute to improved choices and reduce collection problems.

8. The extent of notice of patient financial participation should be consistent with current practice involving physicians.

9. The opportunity for patient financial participation carries with it the risk of bad debts and of public relations problems.

10. Discretion in billing for patient financial participation is essential. For example, it will be desirable to not bill very small amounts which a formula may indicate can be billed.

11. In the event patient financial participation is optional, it is likely that few providers will elect the option, particularly early in a new program.

12. Patient financial participation has the potential to distort decisions, contribute to adverse selection and foster differences in quality.

VI SCOPE

A An integrated payment arrangement which meets the needs, not only of acute inpatient services, but ambulatory, long-term care and other services, is desirable. The payment system should promote selection of cost effective levels of care.

B Cautions and Considerations

1. Different payment arrangements for inpatients and outpatients may distort cost effective choices. Less costly outpatient service that achieves health outcomes comparable to inpatient service should be encouraged.

2. Lack of coordination between inpatient and outpatient payment arrangements can encourage system abuse.

3. Payment arrangements should encourage provider involvement in ambulatory surgery, laboratory, pharmacy and other services to more effectively use existing facilities and thereby lower total healthcare costs.

4. Consideration should be given to meeting all financial needs related to teaching activities and provision of service to those unable to fully pay separate from payment for services.

5. While a system meeting the needs of all providers is desirable, there are special circumstances of small and rural providers. For this reason and because the financial impact of these providers is minor, optional participation by these providers in a new system, particularly its early phases, is appropriate.

VII FINANCIAL REPORTING

A The current Medicare payment system and some other payment systems rely on cost, budget and financial data to an excessive extent. It is more appropriate for payors to be concerned with price. Preparation and submission of detailed financial reports to payors should be unnecessary. Elimination of the present complex Medicare type cost report is essential.

B **Cautions and Considerations**

1. The cost of preparing, submitting, receiving, processing, verifying, compiling, using and adjudicating these detailed financial reimbursement reports is very large. Eliminating these costs can contribute to achieving desired reduction in healthcare costs.

2. The desirability of eliminating these detailed financial reimbursement reports reinforces the desirability of implementing a system which does not require such reporting as soon as possible.

3. Continued availability and reliance on detailed cost data for individual providers will likely undermine any prospective payment arrangement.

4. To the extent cost data is needed, it should be available from regular audit reports. To the extent payors need special financial information, it should be collected on a statistical sample basis. Universal, inclusive cost data serves no constructive purpose.

VIII UTILIZATION

A Utilization involves frequency, duration and mix of services. There should be assurance that needed care is provided and safeguards to avoid overutilization, "skimming," "dumping," "churning," or manipulation. While patient financial participation may provide some control of utilization, some independent monitoring or control system is also likely necessary.

B **Cautions and Considerations**

1. Physicians must have an active role in utilization control -- another argument for closer involvement of the physician as described below under "physician involvement."

2. Provider, medical society, industry and insurance representatives could be included on utilization review panels.

3. Malpractice fears can sometimes contribute to over utilization. Arbitration, settlement limits and other arrangements which balance risk and cost are needed.

4. Training of physicians to be more sensitive to the need for utilization control is needed.

IX PHYSICIAN INVOLVEMENT

A A major objective of any change in payment arrangements is to influence demand. The physician must be involved in the new payment system in a manner consistent with the role as gatekeeper to resource utilization.

The physician must assume risk consistent with this role. Current payment systems generally reward physicians for providing longer and more technologically sophisticated programs of service. Therefore, new payment systems for physicians as well as for institutional providers must be devised. Additional steps to encourage cost effective physician behavior are essential. Physicians are an indispensible and inseparable part of the cost control team. The new payment arrangement must promote and encourage the physicians to assume this role.

1. HMOs or IPAs are means by which physician involvement and a realignment of risk can be achieved.

2. Physician control or influence over insurance payment rates can be reduced.

3. New payment arrangements which involve physicians can be devised, such as combining Medicare Part A and Part B benefits and dividing those benefits between physician and institutional providers in ways which provide improved incentives.

B Educational programs for physicians on cost of resources should be implemented and can include:

- Courses in medical school

- Continuing education courses

- Lists of services with related charges or other descriptive material about charges for services

- Information about least costly care alternatives

- Data describing the influence of service practices on price

X EXCEPTIONS AND DISPUTES

A A process for dealing with exceptions is essential. Disputes must be resolved promptly, impartially and decisively.

XI UPDATING PAYMENT RATES

A Recognition of inflationary and other economic changes should relate to factors reasonably related to and controllable by the individual providers. Changes in payments should fully reflect changes in technology and volume. Recognition of significant case mix* changes should be included either through an institutional case mix index or through rates reflecting current services provided. Arbitrary limits which fail to consider these factors are inappropriate.

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*"Case mix" is used herein to encompass all diagnostic measurement systems.

Updating must be no less often than annual and should not be applied retroactively. Adjustments to compensate for forecasting errors should be promptly included on a prospective basis with consideration of the time cost of money. A system for adjustment in unusual circumstances must be provided. The updating system must be free from bias. Regular updating based on new cost data is undesirable as is described above under "financial reporting."

B **Cautions and considerations**

1. Present means for measuring case mix change and relating these measures to resource consumption are in an early stage of development. Severity of illness and intensity of service are not adequately measured in current systems. Refinement of these measures and relationships should continue to minimize cost and potential for manipulation.

2. For some services, such as long-term care, case mix measures are so poor that use is inappropriate.

3. Case mix related systems may not adequately measure the very complex cases specialty providers serve.

XII THIRD PARTY PAYOR ARRANGEMENTS

A 1. For payors responsible for a large number of patients, an average rate per discharge is an acceptable unit for most acute care service. Other arrangements, such as an average rate per day or charges for individual services, are also acceptable. A method which considers the characteristics of the group of patients for which each payor is responsible is necessary. For example, if prices are based on a provider's historic cost trend, the historic trend for the specific group of patients for which a price is being established should be used -- not the historic trend for all patients.

2. For acute cases with unique length of stay characteristics, or for outpatient services, emergency services or long-term care services, daily rates or rates for individual services are most appropriate.

3. Basing prices initially on an individual provider's financial requirements is acceptable. A system that rewards efficiency achievements is desirable but a reliable and workable system to achieve this objective is not yet available. A rate derived by grouping and comparing providers is undesirable.

4. Prompt payment of the full amount of financial responsibility is essential.

B **Cautions and Considerations**

1. Interinstitutional comparison has not been adequately developed to consider differences in size, location, labor factors, patient mix,

range of services, type of ownership and other factors that distinguish one provider from another. Even if these factors could be considered, the complexity, regulatory cost and government intrusion would likely make such a system undesirable. Accordingly, any system of setting rates or evaluating financial performance which depends on interinstitutional comparisons is undesirable.

2. It is desirable to refine historic data to establish a proper basis of future payment. This requires disposition of the many disputes which are under appeal or litigation or are in the process of being asserted. This quest for refinement must be balanced by the cost of resolving disputes. Furthermore, if resolving disputes does not increase total resources devoted to health care, the effort may only influence the apportionment of funds between providers rather than the amount of funds to be apportioned. For example, resolving the malpractice insurance issue, which influences all providers in a similar way, may have little or no influence on future payment rates (recovery of past deficiencies is possible, however).

3. Basing payments on historic cost fails to reward providers that have achieved efficiencies and may penalize these providers in later years.

4. Basing payments on historic cost is only acceptable for an interim or transition period after which the inherent weaknesses of the system will render it unacceptable.

5. When multiple payment arrangements are used, they should be mutually supportive, practical and understandable. For example, charging for individual cases on the basis of individual services but charging for groups of cases on the basis of group averages can be confusing, particularly to patients paying their own bill. The confusion is compounded when both systems apply to the same case as would occur if there is patient financial participation.

6. The unit of service will have to be carefully defined for each basis of payment. For example, an average rate per discharge which is not adjusted for case mix would not be an acceptable unit of service if rates are determined through competitive bids.

7. Using the provider's own charge structure as a basis of payment is appealing but if charges are uncontrolled, the potential for abuse is acknowledged. Suggestions for a workable system to control individual provider charges for this purpose are not available for evaluation. Furthermore, a system which would provide adequate control would likely be too burdensome and intrusive to be acceptable.

Healthcare Financial Management Association
Adopted May 28, 1982; revised on January 10, 1983

Senator DURENBERGER. Mr. Ryan.

STATEMENT OF WILLIAM H. RYAN, PARTNER, DELOITTE HASKINS & SELLS, NEW YORK, N.Y.

Mr. RYAN. Mr. Chairman, my name is William Ryan. I am a partner with Deloitte Haskins & Sells, an international public accounting and consulting firm. And with me today is Al Cardone, another partner of ours who has just finished an extended term as chairman of the AICPA Committee on Health Care.

The reason I invited myself down here today I guess is being one of the veterans of the rate setting wars going all the way back to when the Maryland Commission was first formed in 1971—I served as their principal consultant through the evolution of their methodology and the issuance of their rates. And about 7 years ago I spent a few Sundays writing a proposal to HCFA to fund and support a DRG project for the State of New Jersey. And I have been involved, and still am, with that system.

And I would just like to give you some comments I would like to make on the proposed methodology based on this experience.

The first one is going to deal with equity among payers. And I know it is not going to be any more popular when I make it today than when I first made it in 1972 to the Maryland Commission, which was established largely to control the runaway medicaid budget in the State of Maryland, the same situation that you are under right now. And in our very early discussions we got to discussing full financial requirements for hospitals. At that time, medicaid was paying under essentially the same ground rules that medicare is paying today. And a very hasty analysis didn't take very long to do, and indicated that if all payers—since that was what the Commission was to cover—paid on medicare's rule, hospitals would soon be bankrupt. And the major shortfalls are in the area of capital for plant and equipment because periods of inflation, even funding depreciation does not keep pace with the capital needs to maintain plant and equipment, working capital, and that proverbial problem, uncompensated care.

But after wrestling with this for a while, the Maryland Commission decided that the only right thing to do was to recognize the full financial requirements, and to try to keep them as reasonable as they could in budget reviews and things like that with the understanding that the medicaid payments would probably initially escalate, but in the long run, the equity of that system and the controls that would be inherent in it would come back and repay the medicaid program several times over.

And, today, I understand that Maryland is considered one of the models of reimbursement, and cost containment. Hospitals are financially viable and it is a good system there in that State. New Jersey also adopted those same principles. And in New Jersey in the DRG rates, a price leveling factor—but working capital provisions and a share of the bad debts.

Medicare has always taken the position that since medicare pays for all of the costs of older people—wants you to pay for any of the costs of younger people. Medicaid has said, well, gee, we pay for the cost of all the poor people so why should we pay for the cost of unpoor people? And Blue Cross can take the same attitude with respect to its subscribers because to its logical conclusion, you might say that anybody who pays a hospital bill belongs now to the population of people who pay bills and, therefore, should not be liable for the people who don't pay bills.

In other words, whatever component that Sears, Roebuck might have in its pricing to cover shoplifting should be paid only by shoplifters.

But in any event, one of the things we would like to suggest to it—we know it's not possible, probable right now in your budget crunch—but the DRG system as conceived right now if it is implemented will save you an awful lot of money. Just compile the history of 10 hospitals for the first couple of years in New Jersey, 10 of the first 26, and it was found that between 1979 and 1981 reduced the length the stay of medicare patients an average of almost 16 percent. And the increase in operating costs was about 11 percent below the national average.

And to answer a question that Senator Baucus had raised earlier, nursing staffing per patient day has actually gone up in New Jersey. But because the length of stay has gone down, the nursing cost per admission, staffing per admission, has remained fairly constant.

The only other comment we would like to make deals with the homogeneity or lack thereof of DRG's is only a state of the art. We would support that concept in the sense of being useful for the vast majority of the patients. If you will turn to the bottom of page 8 of my testimony, there is a short table there that indicates that for a fair amount of the patient population the length of stay within DRG's tend to be 2, 3, 4, 5, and 6 times the average of the patient within a given DRG. There is an element of severity of illness or something that is not now being measured within DRG's. And rather than say let's stop the world until we can refine the DRG definition, I would suggest that the one-half of 1 percent target that the administration now has for DRG's is just far too extreme to implement equitably in the hospital field for medicare.

If you are going to use them at all—and I suggest you do use them—what you are going to need is a more generous or more liberal trim point until the world can answer why do certain patients stay 3, and 4, and 6, and 7 times the average within a DRG. You may have to allow perhaps 10 to 20 percent of the patients to be outliers.

But I would suggest that you use the proposal by the administration for reimbursing those patients. And that is to pay the DRG rate up to the point where they become outliers and then incremental cost beyond that. But rather than put the hospitals at risk for 30, 40, and 50 days due to chance, why not decide that there is a risk that we can live with, and that the hospitals will find tolerable. It may be 7 days above the DRG standard. It may be 10. It may be twice. But I don't think the industry can live with one-half of 1 percent or even 2 percent outliers.

And just two other quickies. There are some differences among whole classes of hospitals that can be measured today. In fact, I think HCFA has done some analysis that indicates, for example, the teaching hospitals with the under-reimbursed and nonteaching hospitals over-reimbursed—put a national standard in. I think the reason for that is variations in severity of illness within DRG's that are not right now accounted for. And rather than wait 3 or 4 years until those confinements can come in it may be appropriate to say, OK, if you are a teaching hospital, we will pay you 105 percent of the national standard because we know there is 5 percent of your cost that we can't account for. And for the nonteaching, we will pay you 95 percent.

Also because of that, I would be inclined to phase in the rate setting system something along the line of TEFRA. There is a sharing between the hospital costs and your national standards, and a gradual ratcheting down of the 223 limits.

Senator **Durenberger**. Thank you very much.

[The prepared statement of Mr. Ryan follows:]

STATEMENT OF WILLIAM H. RYAN, PARTNER, DELOITTE HASKINS & SELLS

Mr. Chairman and members of the Committee, I am William H. Ryan, a partner of Deloitte Haskins & Sells, an international public accounting and consulting firm.

I was the partner in charge of our firm's services to the Maryland Health Services Cost Review Commission from the time the Commission was first formed through the issuance of hospital rates paid by all payors in that state. I have also been extensively involved with New Jersey throughout the DRG project, beginning with helping to prepare the original proposal to HCFA and continuing to this day. I am pleased to have this opportunity to share with you the benefits of this experience regarding your consideration of a prospective payment system for Medicare.

My testimony will address two broad objectives that I believe should be sought in any payment system, once economic and efficient cost levels have been defined.

(1) Equity among payors

(2) Equity among hospitals

Equity Among Payors

The legislation that created the Maryland Commission specified that hospital rates should be applicable to all payors without undue discrimination among the various payors. Thus, subject to reasonable differentials, the State's Medicaid program was to pay the same rates as other payors. At that time, the Maryland Medicaid program was reimbursing hospitals based upon Medicare's narrow definition of historical costs, which are substantially less than the true economic costs of delivering health care. Our initial analyses of Maryland hospitals indicated that if all parties paid hospitals based upon Medicare's cost definitions, it would bankrupt the industry. The major economic shortfalls to health care providers are in the areas of capital costs, working capital needs and uncompensated care.

Any expansion of the financial elements included in provider payment rates would of course, directly increase Maryland's Medicaid expenditures. This fact confronted the Commission with a difficult problem because containing the rapid increase in Medicaid costs was a compelling force behind the enabling legislation. And, Medicaid hospital care is one of the largest items in state budgets.

I participated with the Commission in lengthy discussions of this concern, during which the Commission adopted the following goals:

. to be equitable to hospitals in recognizing all of the elements of economic costs incurred in providing health care

- to carry out its duty to the public to ensure that these cost levels are reasonably related to the efficient production of services, then
- to have each payor, including Medicaid, pay its fair share of reasonable economic costs.

The wisdom of this strategy has been apparent over time. Although Medicaid expenditures did increase initially, the containment of cost increases has more than made Medicaid whole.

The industry is healthy financially. The absence of cost shifting has held customer insurance premiums to reasonable levels.

In parallel circumstances, New Jersey adopted substantially the same goals. Full reasonable financial requirements are included in all DRG rates, including those paid by that State's hard-pressed Medicaid program.

I will briefly discuss those financial elements not now reimbursed nationally under the Medicare principles of reimbursement that have been recognized by these two states in their rates to all third party payors.

- Equipment costs

  Even if fully funded, depreciation on equipment, including compound interest, will not provide sufficient funds for the replacement of the original equipment where costs are impacted by inflation (unless interest rates are extraordinarily high in relation to inflation). A price-leveling component must be recognized in rates.

Building costs

The same phenomenon is true of buildings. In periods of inflation, payments limited to historical cost depreciation (even if funded after debt principal payments) erode capital. The original "down payment" percentage will not be available when it comes time to replace the facility. Again, a price-leveling factor must be recognized in determining economic costs.

Working Capital

Inflation also increases accounts receivables, meaning that some revenue is not available to meet cash needs for payroll, vendors and debt service. To the extent that Medicare payments may lag beyond the providing of services, this consideration should be recognized in payments.

Uncompensated care

This is a particularly problematic area. Medicare has always contended that it pays for all the costs of older people, so why should the program pay for uncompensated care to younger people? Similarly, the Medicaid program contends that it pays the full cost for poor people, so why should it pay for any care to "unpoor" people? Blue Cross can make similar arguments for its subscribers. By logical extension, anyone who pays a bill in full can contend that he or she belongs to the population of payors who pay bills and therefore should not be liable for those who do not pay bills. By analogy, one might argue that whatever component exists in Sears Roebuck's prices to cover shoplifting losses should be paid only by shoplifters.

Just as shoplifters (and bad debts) are economic costs of retail businesses, so are bad debts an economic cost of providing health care. In all fairness, Medicare should recognize this fact.

To the extent that Medicare does not pay full financial requirements, these resources have to come from other sources, namely, the public, which, of course, is also the source of federal revenues. While in the aggregate, this simply shifts the making of payments from the public's taxpayer pockets to its consumer pockets, the burden of making up the shortfall from Medicare (and Medicaid) falls disproportionately among both payors and hospitals, particularly in areas with large indigent populations.

Congress explicitly recognized this problem in the Omnibus Reconciliation Act of 1981 (PL97-35). Section 2173 requires that States' Medicaid rates take into account situations of hospitals that serve a disproportionate number of low income patients with special needs.

I am well aware of the budgetary pressures regarding the federal deficits, and the realities of the situation may be such that no immediate consideration could be given to Medicare's paying full economic costs without a quid pro quo from hospitals in the form of Medicare cost reductions. Such an approach may be workable, if not now, then as hospitals respond to the incentives inherent in a prospective system.

Under TEFRA, savings below target costs are to be shared equally 50/50 between hospitals and the Medicare program. As a reward for a hospital that comes in under the target, for example, you might consider a 100% hospital incentive zone equal to those economic costs not now included in its Medicare payments. Once these costs are recovered by the hospital, sharing could revert to the 50/50 formula.

If New Jersey's results under DRGs are representative of what Medicare can expect under a comparable payment system, the savings to the Federal Government could be considerable. We have recently compiled the results of a sample of 10 of the original 26 New Jersey hospitals who were on the system for the initial two year period ending December 1981. Representative of their performance during this two-year period for these hospitals were that

. hospital costs per admission rose 11% less than the national average

. average length of stay of Medicare patients decreased 15%

To the extent that Medicare realizes significant savings through the prospective payment system, we recommend that a provision be developed to return a fair portion of such savings to hospitals in the form those cost elements not now included in Medicare rates.

We strongly believe that health care providers' financial requirements should be met in order to preserve the fiscal viability of the overall health care system for the future. Redistribution of the savings achieved under the prospective payment system to those providers who have demonstrated their ability to improve their operational efficiency would be in the best interest of both the providers and the Medicare program.

Additional payments to satisfy a provider's financial requirements - presently not included as a reimburable cost - would provide another powerful incentive to improve operating efficiency; it would also go a long way toward reducing the risk of efficient health care providers being forced out of the system because of their inability to meet those previously described costs like bad debts, and the shortfalls in capital reimbursement caused by inflation.

Equity to Hospitals

The Administration proposes to base the prospective payment system on rates by Diagnosis Related Group (DRG).

DRGs are the current state of the art in classifying patients for establishing rates. Based upon our experience in New Jersey, we endorse the concept in principle as the best approach now available.

To achieve the objectives of the prospective payment system with equity among hospitals, however, it should be recognized that DRGs are only the present state of the art and are by no means ideal for classifying all patients.

We, and others, have expended considerable efforts in analyzing variations in costs and length of stay among patients within DRGs as they are now defined. While the lengths of stay of the vast majority of patients tend to be reasonably clustered, there is a significant portion of patients that are atypical within given DRGs, often with stays of several times that of the typical patient.

We selected for analysis New Jersey patients in a random sample of 12 high volume DRGs applicable to older patients.

The percent of patients with atypical lengths of stay (LOS) in these DRGs were as follows:

LOS As Multiple Of Typical LOS	Percent of Discharges
Over 2 times	13.6%
Over 3 times	5.1%
Over 4 times	2.65
Over 5 times	1.4%
Over 6 times	.8%

For this purpose, the "typical" length of stay was defined as the average length of stay of those patients not classified as outliers by New Jersey's definitions of outliers for each DRG.

Based upon the above analyses, it is apparent that the DRG classification system is not sufficiently refined to account for patients with atypical lengths of stay. Studies by Johns Hopkins and others have indicated that additional criteria such as severity or stage of illness is necessary to account properly for these patients.

Until such enhancements can be built into the patient classifications system, we urge that the payment system be designed in such a fashion that hospitals who have disproportionate number of atypical patients are not unduly penalized. Such could happen for a variety of reasons, e.g.

- Simply by chance, which could severely impact smaller hospitals where laws of large numbers cannot be expected to apply
- Larger teaching hospitals, because they treat more complex cases, may have a disproportionate number of them embedded in their case mix

Also, the failure of a system to give adequate consideration to such patients could lead to undesirable "gaming", whereby individual hospitals could discourage their admission and try to send these patients elsewhere.

We believe that the only workable short-term solution to this problem would be to liberalize the Administration's proposed definition of outliers - that is, atypical patients. If the definition of outliers is implemented as now proposed, hospitals would lose several weeks of payment per patient on these cases, with the result that billions of dollars could be maldistributed or distributed more or less by chance.

Thus to achieve the objectives of the system with equity to hospitals, it may be necessary and desirable to treat perhaps 10% to 20% of patients as outliers.

For these outliers, the payment would consist of the DRG rate up to a limit (trim point) in terms of length of stay, after which a rate geared to variable costs would be paid.

Under this approach, hospitals would still have the incentive to discharge all patients as expeditiously as possible. They would lose money on every outlier; however the individual losses would be more tolerable in amount.

Under a "budget neutral" approach in calculating rates, a further advantage is that the DRG payment standard would be lower, because more funds would be reserved for reimbursing for the costs of outliers beyond the trim points. Thus, the standards against which hospitals would measure physicians' performance would be lower and more representative of the typical patient population. Such would provide additional incentives to reduce the length of stay of the typical patient, a major objective of the prospective payment system.

In summary, applying prospective rates entirely to 80% to 90% of all patients, and in part to atypical patients, is perhaps as far as the current state of the patient classification art can safely be applied without introducing an undue measure of chance, inequity and possible gaming.

For much the same reason, we would encourage a phasing in of the system. The Administration has acknowledged that inaccuracies and inadequacies of data may well have impaired the validity of its calculations. Further, DRG definitions may still by undesirably broad even with more liberal definitions of outliers. Some hospitals or classes of hospitals may have disproportionately high lengths of stay and costs within DRGs resulting from imprecisions in measuring their patients accurately under the current DRG classification system.

Under TEFRA, there is a graduated ratcheting downward of the Section 223 limits (based upon case mix) to 110% of a national standard. There are also provisions for sharing performance against target rates between hospitals and Medicare for the first two years.

We recommend that some similar form of phasing in be considered under a prospective system based upon DRGs, at least until the patient classification criteria can be sufficiently refined to permit the equitable implementation of national payment standards that could be completely independent of the actual level of each hospital's operating costs.

The extent to which whole classes of hospitals would gain or lose under national DRG payment standards can be measured from data now available. We believe it would be appropriate initially to predicate the system on the assumption that such variations are the result of unmeasured variations of case mix within DRG and, accordingly, establish differentials from national averages, by class of hospital that would be factored into payment rates.

Senator DURENBERGER. Ms. Simons.

STATEMENT OF MS. SALLY SIMONS, R.R.A., AMERICAN MEDICAL RECORDS ASSOCIATION, CHICAGO, ILL.

Ms. SIMONS. My name is Sally Simons. I am representing the American Medical Records Association, representing 25,000 credentialed medical records practitioners across the country. We are glad to have the opportunity to testify today and to share our views on prospective reimbursement.

Medical records departments in hospitals have long been the source for clinical data input for all purposes—patient care, research, epidemiology, as well as third party payment. Now with the possible implementation of DRG's as a nationwide reimbursement mechanism for medicare patients, data collection and reporting will be the supporting vehicle for the fiscal health of the hospital, not only directly for billing but also indirectly for management reporting. A valid data base is essential to both the Federal Government and the individual hospitals in order to address areas of inefficiency in delivery of care, the overall purpose of the prospective payment.

We speak to these issues based not only on experience with the New Jersey DRG's but also with our expertise as medical records professionals whose training has long focused on data collection, classification and reporting. Medical record practictioners have always been concerned about quality data. Utilization of data for reimbursement will not alter our pursuit of that objective. Because of these concerns, we ask you to consider these data quality issues, which are more completely detailed in our written testimony.

No 1, how will data be defined under prospective payment? DRG's are calculated on many complex variables, such as principal diagnosis, significant secondary diagnoses and operative procedures. In developing any nationwide system it is imperative that all participants understand the variables and that they be clearly defined. The rules or terms for national clinical data reporting have been defined in the UHDDS. But the New Jersey experience has shown that even these terms need to be further clarified and expanded so no potential for misinterpretation or fraudulent use of the data can enter into the report process.

For instance, just sudden rephrasing of identical medical conditions can result in different DRG numbers with a very large dollar discrepancy.

The second point we would like for you to consider is how will the data be collected. Consideration must be given to how data are collected for the future. The MEDPAR data as the base we feel is seriously flawed because of the data collection methodology. The data were collected in hospital billing offices. Frequently this information was collected from a patient on admission to the hospital and was an inadequate picture of the patient's subsequent hospital course and resource consumption. We strongly feel that a national system which can determine the future health of the Nation's hospitals should be based at a minimum on a valid data base. Future data reporting, therefore, should be designed to obtain data from the source documents, the medical records, and hospital staff personnel who have access to physicians for necessary diagnostic information.

Third, how will outliers be defined under the system? As Mr. Ryan has emphasized, DRG's are based on the theory that for each DRG for which a rate is established clinically coherent and thus can be an accurate predictor of cost per case in resource consumption. Each DRG defines the product the hospital offers, and the DRG rate is the price for that product. However, there are some DRG's that due to the nature of their composition are not homogeneous in nature and thus cannot be an accurate predictor of price. And, therefore, are unsuitable for prospective payment.

In New Jersey, cases falling outside the system are termed outliers and are not billed on the DRG rate. The Secretary's proposal allows only those cases with a very high length of stay to be considered outliers. In New Jersey we have found a number of other cases which do not meet these criteria, and we would like the Congress to look at those additional areas.

Finally, we are concerned that aspects of the proposed revisions as to conditions of participation will be contradictory to the aims of timely data collection. Proposed revisions would extend the time for a physician documentation in the medical record and completion of it considerable. Such a delay will hinder reimbursement, but has the potential for encouraging less accurate information. Ironically, the proposed revisions also eliminate the requirement for credentialed medical records personnel in a hospital at a time when the presence of trained personnel is crucial to the success of prospective payment.

In conclusion, we offer the assistance of the American Medical Records Association in developing prospective payment. DRG's were developed at Yale and refined at the New Jersey experiment both with clinician input and medical records input. And I think it has really helped to give credibility to the data base.

Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Ms. Simons follows:]

STATEMENT OF

THE AMERICAN MEDICAL RECORD ASSOCIATION

Chicago, Illinois

BY SALLY SIMONS, RRA

SUMMARY

The American Medical Record Association representing 25,000 medical record professionals nationwide has a continuing concern for the quality of data generated in this country's hospitals. That concern extends to data used for reimbursement, and we offer the following considerations:

-Need for clear definitions of data - In developing a prospective payment system to be used nationwide, clear definitions of terms are necessary for uniform reporting and interpretation of data. We recommend adherence to the already established uniform hospital discharge data set.

-Need for Accurate Data Base - A national system of reimbursement based on clinical data should have accurate data available. We recommend that future data reporting be designed to obtain data from the medical record by personnel trained in disease classification.

-Need for Clinically Coherent Case Mix - The New Jersey DRG experiment allows several types of atypical cases to be reimbursed for cost, rather than by DRG classification. We encourage Congress to look closely at the prospective plan's allowances for such atypical cases.

-Need for Guidelines for Medical Record Departments - Proposed revisions to the Hospital Conditions of Participation would lengthen the time for record completion and delete the requirement for credentialed medical record professionals. In order for prospective payment to succeed, accurate and timely data is needed. We ask the Committee's support in retaining strict guidelines for medical record departments and their personnel.

Finally, we offer the expertise of the American Medical Record Association as a prospective payment system is designed.

My name is Sally Simons, and I am the Director of the Medical Record Department at Overlook Hospital, Summit, New Jersey, one of the original 26 DRG experimental hospitals. I am here testifying on behalf of the American Medical Record Association, an organization representing 25,000 medical record practitioners across the country. We are glad to have the opportunity to testify today and share with you our views on prospective payment and the concept of DRG's as spelled out in Secretary Schweiker's Report to the Congress in December of 1982.

In our role as medical record practitioners, we have several points we would like you to consider as the prospective payment system is developed. Medical record departments in hospitals have long been the source for clinical data reporting for all purposes - patient care, clinical research, epidemiological studies and third party payment. Now with the possible implementation of DRG's as a nationwide reimbursement mechanism for Medicare patients, data collection and reporting will be the supporting vehicle for the fiscal health of the hospital, not only directly for billing but also indirectly for management reporting. Such reporting is essential to both the Federal government and the individual hospital in order to address areas of inefficiencies in delivery of care, the overall purpose of the prospective payment plan.

We speak to these points based both on our experience with the New Jersey experiment which has utilized DRG's as the reimbursement method for all payors since 1980, and from our experience and expertise as medical record professionals whose training has long focused on data collection, classification, and reporting. Medical record practitioners have always been concerned that data reported are accurate and timely. Utilization of these data for reimbursement will not alter our pursuit of that objective. Because of these concerns, we ask you to consider the following points:

1) DATA DEFINITIONS - DRG's are calculated on certain variables: principal diagnosis, significant secondary diagnoses (hospital complications and other conditions which existed at the time of admission and which have an impact on the length of hospital stay), age, operative procedures, and other variables such as discharge status which are unique to certain DRG's. In developing any nationwide system, it is imperative that all participants understand the rules of the game and that the rules be clearly defined. The rules or terms for national clinical data reporting have been defined in the Uniform Hospital Discharge Data Set (UHDDS). The New Jersey experience has shown that even those terms need to be further clarified and expanded so no potential for misinterpretation or fraudulent use of data can enter into the reporting process. Some misunderstanding of terms surfaces in the Secretary's report on Page 97 in differentiating principal from primary diagnosis. Such distinctions must be clearly defined or the potential for inaccurate reporting and data manipulation will exist. The variables must be defined in such a way that all mean the same to each institution reporting. We recommend adherence to the already established and disseminated definitions of the UHDDS.

2) DATA COLLECTION - Consideration must be given now to how data are collected for the future. The MEDPAR data base, we feel, is seriously flawed because of the data collection methodology, a fact which the Secretary admits on page 93 of his report to Congress. The data were collected in a narrative form in hospital billing offices. Frequently this information was collected from the patient on admission to the hospital and was an inadequate picture of the patient's subsequent hospital course and resource consumption, information which can only be fully determined at discharge. Further, the data were classified at HCFA according to the ICD-9-CM classification system without access to either the source document - the medical record - or

the treating physician. Additionally, the data fields on the MEDPAR bills were inadequate for total representation of the patient's clinical picture. The Secretary states that the data for establishing rates are inaccurate, but that the inaccuracy is of no consequence as it is to the hospitals' advantage. We feel strongly that a national system which could determine the future health of the nation's hospitals should be based on the best available data. Future data reporting, therefore, should be designed to obtain data from the source document - the medical record - by hospital-based personnel who are trained in ICD-9-CM classification and who have access to the treating physician for necessary diagnostic information.

3) DEFINITION OF CASE MIX - DRG's are based on the theory that each DRG for which a rate is established is clinically coherent and thus an accurate predictor of resource consumption. Each DRG defines the product the hospital offers, and the DRG rate is the price for that product. However, there are some DRG's that, due to the nature of their composition, are not homogeneous in nature and thus cannot be an accurate predictor of price and are unsuitable for a prospective payment plan. In New Jersey, cases falling outside the system are termed outliers and are not billed on the DRG rate. The Secretary's proposal allows only those cases with a very high length of stay to be considered outliers and to be paid more than the typical DRG rate. In New Jersey, we have found a number of other cases in which the experience is so unusual that no accurate prediction of resource consumption can be made and no rate generated. The cases are:

a. Death (Patients who expire consume an abnormal number of resources.)

b. Low volume outliers (There may be diagnoses in which the occurrence is too minimal to predict a rate, such as Legionnaire's disease.)

c. Discharge status (Patients who leave against medical advice or are transferred to another facility are not reliable predictors of resource consumption.)

d. Low outliers (Patients who stay well below the average length of stay are considered low outliers. Patients who could be treated in ambulatory care settings could be admitted as inpatients to gain the DRG rate if provision for low outliers is not included in the plan.)

e. Clinical outliers (In New Jersey, we consider clinical outliers to be those DRG's into which a number of unrelated diagnoses and/or procedures are lumped. The diagnoses or procedures included do not necessarily relate to each other and are not accurate predictors of resource consumption. In New Jersey, these clinical outliers are billed on charges, not the DRG rate. As an example, one DRG includes virtually any procedure performed in an operating room and unrelated to the principal diagnosis, ranging from vasectomy to removal of a malignant brain tumor.)

We would encourage the Congress to look more closely at outliers if a clinically coherent system is to be established.

Finally, we would like to offer the assistance of the American Medical Record Association in the development of the prospective payment plan. The 467 ICD-9-CM DRG's were developed at Yale and refined in the New Jersey experiment with the assistance of clinicians and medical record practitioners who helped clarify data reporting and whose knowledge of coding and uniform definitions lent consistency to the data base used for rate setting.

Further, we are concerned that aspects of the proposed revision to the Conditions of Participation will be contradictory to the aims of timely data collection and reporting. Proposed revisions would extend the time for a history and physical from 48 to 60 hours after admission. The first hours of patient treatment are crucial, and to delay the documentation of basic patient health information could be a detriment to the quality of communication among those treating the patient, and to the efficient use of hospital resources. Second, the proposal would double the time, from 15 to 30 days, allowed for completion of the medical record. Such a delay will not only hinder the reimbursement process, but has the potential for encouraging less accurate information than that documented closer to the time of discharge. In addition, the proposed revisions would eliminate the requirement for credentialed medical record personnel in hospitals. Although we are sympathetic to the Administration's desire to give hospitals flexibility in the way they operate, we feel the presence of trained medical record practitioners is of such importance to the success of the prospective payment system that requirements must be maintained to have skilled personnel providing data to the Federal government. To eliminate the requirement is to allow hospitals to train medical record personnel themselves, a situation which could lend itself to inaccurate and unfair data reporting. We ask your support in retaining strict medical record requirements so the prospective payment system has the greatest potential for success.

I will be glad to answer any questions the Committee may have.

Senator Durenberger. Let me ask my first question of you, Ms. Simons. It concerns the issue of timing. The administration suggests that we put this in the system in place on October 1. Based on your testimony and your experience, would you comment on the reasonableness of that recommendation?

Ms. Simons. I feel that it is a good idea, and I would concur with your suggestion this morning, Mr. Chairman, that a nationwide commission be appointed to evaluate with input from clinicians, medical records personnel, hospital financial managers, the association people, the type of people who could effectively evaluate the system as it is underway.

Senator Durenberger. That was Senator Baucus' recommendation. It's probably a good one. I'm sure he appreciates the endorsement.

But you do not think that it would not be difficult to put this into effect almost immediately?

Ms. Simons. I think it can be done.

Senator Durenberger. All right.

Mr. Kovener. An appropriate phasein process is really very important, as has been noted earlier. Dealing with outliers, and dealing with the hospital cost experience will help us get into the system without really jeopardizing hospitals' fiscal existence.

Senator Durenberger. This is a general question for all of you because I have heard it a lot this morning. What's the value of the appeals process and what is an appropriate appeals process? Something that avoids everything falling into the appellate category. Is there something we can learn from experiences we have already had with the appeals process that will tell us how to do it right in the beginning so we minimize the utilization of the appeals process? Do all of you have some observations that you would like to make on that?

Mr. Kovener. I would certainly think that a prospective system would be subject to many fewer appeals than the very, very detailed rule book that we now have, and the difficulty of applying those rules in the host of different kinds of operating situations that we have across the country.

However, our experience certainly shows that there is an awful lot of unexpected situations that can come up. And there are bound to be things in any system, no matter how carefully it has been constructed, that we did not anticipate. There has to be an equitable system for resolving those misunderstandings. In that regard, we feel very, very strongly about the need for some sort of an appeals mechanism. We do not believe that an appeal to the person that makes the rules is an appeal.

Senator Durenberger. Any other comments on that?

Mr. Ryan. Yes. The one concern that has been expressed to me by hospitals is how will changes in medical technology be reflected in DRG payments. And there should be some mechanism established to do that rather quickly because if you wait until cost data comes floating in years later it may take 3, 4, or 5 years for a change. You will need a quick turn around system on that.

Ms. Simons. I think the Yale—as developed, it doesn't necessary have to be a static instrument. I think any kind of ongoing commission that were evaluating the DRG process could also be evaluating the L group or in putting adequate safeguards in place that would address those concerns. The grouper is flexible enough to address that, I think.

Senator DURENBERGER. I have a bunch of specific questions here that I probably had better ask you to respond to after this hearing. Since you are all hired to be part of this system in one way or the other, I would appreciate your views on something that I think Mr. Kovener mentioned when he talked about the importance of physician involvement. And that takes me back one witness when I heard that if people believe they can't contain costs, then they won't be able to contain costs. Between 9:30 and 10:30 this morning we heard from a group of physicians who said they didn't think this system was going to work. And if all those folks don't think this system is going to work, is it likely that it will?

Mr. KOVENER. First of all, the opportunity to save costs is subject to a great deal of misunderstanding. Under the system as it presently exists if a hospital spends $50.00, they are going to get $45.00. And that $5.00 that they spent has got to be paid by somebody. It is spent. And there is no way that medicare will pay anything if the money wasn't spent in the first place. If they only spend $45.00, they are only going to get $40.00. Now if they only spend $40.00, they are only going to get $35.00. And it's that kind of paying less than the cost actually incurred that greatly complicates the process.

Now if we can go to a system where the price is determined and if we can, in fact, deliver that product within the predetermined price, there will be a structure that will allow us to operate in a more cost effective and cost conscious way. And then we can bring the physician into it much more effectively. Right now, the physician has absolutely no incentive to choose a less costly alternative or to reduce the demand for services in any way.

I think that these are natural byproducts of this system, and is the basic reason why we favor this change because we believe it will bring the necessary influence on choice and demand that is essential to achieve the long range cost impact that is necessary. The physician has got to be part of it because right now the physician is continuing to be paid more, the more services he performs. The hospital, on the other hand, is being penalized for following the very rules that the doctor is responsible for establishing.

Senator DURENBERGER. Mr. Ryan.

Mr. RYAN. The system is really, I think, targeted three-quarters to physicians and one-quarter to hospitals. Hospitals can do something about containing their cost levels, but they are not the ones that keep the patients. It's the physician that does it. It's the physician that orders the X-rays and the lab tests. And, therefore, doctors, to me, are the core of what you are driving at with DRGs. I mention that 16 percent reduction in medicare length of stay in 2 years among those hospitals in New Jersey. That wasn't the hospital administrator that was discharging those patients. It might have been the administrators who were encouraging the physicians to discharge them, but the doctors are at the heart of the system.

Senator DURENBERGER. Ms. Simons, any comments?

Ms. Simons. One of the real assets of the DRG system in New Jersey is the development of a very large data base which has allowed us to do a lot of management reporting that we were not able to do before. One of the things that we have been able to do is address individual physician practice patterns in a way that identifies problem areas, and more effectively address them.

There is no question that the physicians control resource consumption in the hospital through the doctors' order sheets. But if we can see and compare length of stay data and overutilization of services through management reporting, we have a much more effective handle on physician education.

Senator Durenberger. Thank you.

Mr. Chairman, do you have any questions?

Senator Dole. None.

Senator Durenberger. Senator Baucus.

Senator Baucus. None.

Senator Durenberger. Senator Bradley.

Senator Bradley. Thank you, Mr. Chairman. Let me ask Ms. Simons—and also ask the Chairman that I hope after these hearings we would have used up the New Jersey quota of witnesses on all of——[Laughter.]

Let me ask Ms. Simons. What effect has the DRG system in New Jersey had on the medical records departments?

Ms. Simons. It has really been able to do things that medical records practitioners have wanted to do all along, which is really to bring good quality data reporting. There is no question that the New Jersey data reporting system has improved enormously over the past couple of years because it is tied down to reimbursement.

Senator Bradley. So you said there is a different emphasis on it essentially?

Ms. Simons. That's right.

Senator Bradley. It received a higher priority in the administration's eyes?

Ms. Simons. And in staffing. And ability to do the kind of things that we need to do to have good quality data.

Senator Bradley. Do you have any thought on how we answer the question of updating the data on changes in technology?

Ms. Simons. That's a very difficult question. There are some DRG's which address that specifically, and there are ways, working within the existing DRG system, to do that. But it really assumes a larger number of outliers than the system accommodates right now.

But, as I say, the DRG grouper itself is not static. And I would think that if it is going to be used as a vehicle for reimbursement it should be continually looked at and updated to reflect those increasing——

Senator Bradley. What you have said is that by the time you wait for the cost information to come in that indicates there is more and different technology that you would then be behind.

Ms. Simons. That's right. You are dealing with a classification system that essentially is only updated every 10 years. ICD9 was introduced in 1979, and won't be revised until 1989. So when any new advance in technology is implemented, there is no way of reflecting that in the new system.

Senator BRADLEY. Do you think that the uniform bill that has been proposed at HCFA is going to improve things, and improve data collection? And why?

Ms. SIMONS. As long as the participants understand the data elements submitted and that they are uniformly reported, it is a uniform bill—the data element should be uniformly defined.

Senator BRADLEY. And you don't think that that is too difficult to manage from a records standpoint?

Ms. SIMONS. I certainly don't.

Senator BRADLEY. All right.

Let me ask the panel generally now. As we consider the system, how do you figure we allocate the cost of capital into the DRG rate? My fear is we are going to get into a system where we are taking care of the operating and not worrying about the capital cost. And if that could ultimately produce the opposite effect that we want.

Mr. RYAN. I don't see any reason to leave equipment type of capital outside of the rate at all.

Senator BRADLEY. When you say "equipment," you want to be more specific?

Mr. RYAN. Movable equipment.

Senator BRADLEY. Do you mean equipment like X-rays and other things, or do you mean the addition to the hospital?

Mr. RYAN. No; the movable equipment. X-ray equipment, lab equipment, computers. There are too many labor capital trade offs available in hospitals. So I think to leave the labor in the system and the capital outside of the system.

Senator BRADLEY. Does the panel as a group feel that way?

Mr. KOVENER. I would concur with that. Yes. If we can start with a system that is related more specifically to the individual hospitals' costs, then the different treatment of capital is not so essential in the early phases, and it will give us a little bit more time to study and evaluate alternatives for dealing with capital.

Senator BRADLEY. So that if you figure in the instrumentation, essentially, movable equipment, into the DRG rate then you have some time to deal with the latter.

Mr. KOVENER. Yes.

Senator BRADLEY. Are you worried about cost shifts in the system? I mean Prudential said about $6 million in cost shifts. Are you worried about that if we go to the single system?

Mr. KOVENER. It's my feeling that the cost shifting, as I tried to express earlier, is a result of the fact that medicare does not pay their share of costs, and there is no way that the hospital can curtail their level of expenditures to be within what medicare will pay. There is no alternative in the present system except to shift the cost. You can't just save the cost. That's not something that works.

If, in fact, you can go to this different system, there would be less need for cost shifting. And as a matter of fact, medicare might well wind up being the recipient of the cost shift at some time in the future because they might be paying a rate and other payers might be able to negotiate a lower rate. That would be a very good possibility.

Senator BRADLEY. Anyone else?

Mr. **Ryan**. Two kinds of cost shifting. There is the shifting that has been going on for the last decade or more because medicare does not pay full financial requirements. In addition, I think under TEFRA there is some danger of cost shifting because of the fairly tight targets. The shifting, therefore, of the medicare losses, if you would.

But, again, if the New Jersey experience is any indication of what may happen nationally, hospitals may start to make money on DRG's, in which case there would be no need to shift cost, the lost cost. There may still have to be the need to shift those other elements.

Senator **Bradley**. Does the panel generally feel that if we went to the DRG system that the administrative costs of implementing it would be manageable? Or do you see significant increases in administrative costs?

Ms. **Simons**. There have been substantial implementation costs in New Jersey. But by and large I think they were costs that probably should have been in hospitals anyway—implementation of integrated data systems, data collection management systems. They probably should have been in place anyway.

Mr. **Ryan**. Outside of costs incurred to get good information, I don't think the administrative costs per se should be enormous. About the way the administration is talking about paying for outliers.

Senator **Bradley**. About what?

Mr. **Ryan**. The way the administration is talking of it as proposing to pay for outliers which is to pay the DRG rate and then an incremental cost, and then that patient is behind us.

Senator **Bradley**. Are you worried about the amount of outliers that would be allowed under the administration's approach? It's considerably less than the experience in New Jersey.

Mr. **Kovener**. Too small.

Ms. **Simons**. Too small.

Senator **Bradley**. What would you recommend?

Mr. **Ryan**. I think you ought to be prepared for somewhere between 10 percent and 20 percent outliers.

Senator **Bradley**. All right.

Mr. **Kovener**. If I could comment on your earlier question about the administrative costs. I think it is going to depend upon what is eliminated at the time that this system is implemented. If this system is implemented as a further layer on top of the existing cost based approach to payment, then I think you are going to have a multiplication of your administrative burden. This year, for example, under TEFRA we have to figure three different rates. We have got a 223 rate. You have got a target rate. And you have got your cost. It has added tremendously to the burden.

But if you adopt this prospective system in a really prospective way and get rid of the cost reports and get rid of a lot of the burden that is inherent in the present medicare system, you can go a great deal toward lowering the administrative cost at the institutional level and at the governmental level.

Ms. **Simons**. I might add that the Yale grouper can be mounted on an Apple computer so even the smallest hospital would have the management reporting capabilities.

Senator **Durenberger**. Thank you very much. We have three hungry New Jerseyites sitting out there. One from South Orange, one from Jersey City and one from Kenilworth who can step forward now.

And we thank you for your testimony.

These are the people with peer review experience in the New Jersey prospective reimbursement system. We welcome all three of you.

Your very complete statement is already part of the record and you may proceed.

STATEMENT OF DENNIS DUFFY, EXECUTIVE VICE PRESIDENT, SUBURBAN MEDICAL REVIEW ASSOCIATION, KENILWORTH, N.J.

Mr. **Duffy**. We will attempt to keep it very brief, Mr. Chairman, since it is getting late.

My name is Dennis Duffy. I'm the executive vice president of the Suburban Medical Review Association. And my colleagues are Marc Allen of Essex Physicians Review, and Robert Cherecwich of Hudson Country PSRO.

We appreciate the opportunity to express our concerns over the proposed reimbursement system's lack of any appropriate quality assurance and utilization review program. As you know, New Jersey has such a review system incorporated into our prospective payment system. And what we would like to do is briefly describe our program. I'm going to sketch our system organizationally. I will sketch our system, and the other gentlemen will describe our review process.

Our organizations are federally designated PSRO's under Public Law 92-603 and designated utilization review organizations under chapter 83 of Public Law 78 of the statutes of the State of New Jersey. We perform medicare review under the Federal statutes and review is performed on all other patients under the State statutes. Our three corporations have approximately 2,900 physician members. Our counties contain three of New Jersey's largest cities, those being Newark, Jersey City, and Elizabeth. There are well over 2 million people in our area, 36 hospitals and approximately a quarter of a million medicare eligibles in the three counties.

With the passage of TEFRA, including the Peer Review Improvement Act of which I think the chairman had some involvement, our organizations are preparing for the implementation of that program by moving toward corporate mergers into a more cost efficient administrative structure. We anticipate saving the Health Care Financing Administration another 25 percent of our administrative cost through this merger.

Unlike most PSRO's in the country, since our commencement of total review, our costs to the Health Care Financing Administration is close to 50 percent less than what it was in 1980.

We have been reviewing medicare patients since 1976. And as of today, have reviewed nearly 600,000 discharges of medicare patients and 1.2 million patients in total all payers.

New Jersey currently has eight PSRO's reviewing all patients in approximately 100 hospitals. This combined program reviews 1.2

million cases annually and boasts a position membership of approximately 6,500 doctors.

I would like to add something that we found out about as we got off the plane last night. I'm very sorry that Senator Baucus is not here. We found out that HHS has decided to do another PSRO evaluation. All PSRO's were told yesterday that they are to provide a detailed report within what we consider a rather unreasonable amount of time. We have also been told that it is nearly identical to the evaluation that was criticized last year by both this committee and the General Accounting Office. We are just extremely concerned that it's an attempt to undermine the intention of the chairman's legislation to phase in peer review once again by the administration. It upsets us. We wanted you to know it.

Senator DURENBERGER. I didn't know it, so it upsets me. Nobody is running that department over there right now so I imagine you can get away with just about anything. Go ahead with your testimony.

Mr. DUFFY. We've been evaluated so much this year that we haven't had much time to do what we are supposed to do.

Anyway, it's well known that the prospective, by the case reimbursement envisioned by HCFA, changes the incentives to hospitals and physicians relative to the delivery of health care. I take particular note in the fact that someone earlier had said that the physicians still run the health care system. One fear and one thing that is ignored by the administration's reimbursement regulation is that physicians will automatically start discharging their patients the moment DRG begins. We have been doing this for a few years, and you still need to prod the physicians. You know, the administrator cannot walk downstairs and say, "Doctor Smith, it's time to get your patient out," because he will go to another hospital, at least in New Jersey. Maybe in Montana or Minnesota it might be a little different but not in our congested State.

Anyway, I will turn it over to my associate, Mr. Allen, who will begin to describe the system we have tailored to perform review under DRG in New Jersey.

STATEMENT OF B. MARC ALLEN, J.D. EXECUTIVE DIRECTOR, ESSEX PHYSICIANS REVIEW ORGANIZATION, SOUTH ORANGE, N.J.

Mr. ALLEN. Mr. Chairman, I would like to take a few minutes to discuss the PSRO hospital review system. In New Jersey, the PSRO's have modified the basic Federal medicare review system to accommodate the changed incentives in the delivery of hospital care and its reimbursement.

Currently, there is no incentive for hospitals to keep services to a minimum because the financing mechanism is based on reasonable cost reimbursement for services rendered. The more services ordered by the physician, the more delivered by the hospital, and the more reimbursement is received.

With price per case prospective DRG reimbursement, the incentive is reversed. The hospital receives a fixed price per case no matter how many resources were consumed. The fear is that needed services may be denied in order to maximize profit within the price per case. The important part is to restrict unnecessary services to a minimum and to provide only necessary services.

We believe that locally directed physician peer review, as is amplified in the PSRO, can provide reassurance that quality care and appropriate use of the hospital setting will occur.

PSRO physicians establish the criteria and standards with which the peers review each other's practice patterns. PSRO physicians review each other's cases on a concurrent basis. This has proven to be more timely, fair to patients, physicians, and hospitals alike. By contrast, Government and fiscal intermediary retrospective data analysis judged by the Finance Committee in 1969 or 1970 to be a failure simply cannot accomplish the same objectives.

Another fear in the prospective reimbursement system is the lack of attention to quality of care because of the new profit incentive. Certain individuals might be tempted to deny necessary services to the aged to maximize reimbursement.

Finally, there is a danger of manipulation of diagnosis coding or DRG assignment to increase reimbursement beyond that what might be expected. This has been referred to earlier as "DRG creep."

Our review process utilizes nurse review coordinators, physician review advisors, who screen hospital cases on a daily basis. The process includes review for necessity of admission and continued stay, as well as review for the use of hospital services—such ancillaries as surgery, lab, X-ray, and others. This combined utilization and quality assessment approach on a concurrent basis clearly identified unnecessary services and admissions as well as underutilization of services and allows us to correct deficiencies in a timely basis.

Upon admission, the nurse coordinator reviews the case using criteria developed by PSRO physicians. These criteria called "severity of illness intensity of service" qualify the patients' degree of illness or problem and measures the amount or level of services required to be rendered at the hospital level.

If the admission is questioned, that is, if it fails to meet the criteria, the case is referred to the physician reviewer for determination after discussion with the attending physician. The reviewer will then approve or deny the case for reimbursement based upon his own clinical judgment. Critics say this peer interaction could be replaced by computer analysis perhaps by the fiscal intermediary. This is simply not the case. The concurrent peer review is more palatable to the medicare beneficiaries due to its timeliness and to attending physicians who appreciate direct peer contact rather than computer analysis.

The second aspect to our review process addresses quality of care. This is important because of the fear of deprivation of the quality of medical care due to the new reimbursement incentives, as we have already heard this morning.

We perform quality review studies directed by physician specialty committees on topics which are for either known or suspected problems in hospitals. One example was a study on bilateral cataract surgery. Ophthalmologists set the criteria and reviewed over 700 medical records during the study and restudy. A physician was found to be performing simultaneous bilateral cataract surgery which we are told presents a high risk of infection and potential blindness to both eyes. The committee required the physician to stop performing this procedure. Since no one died or became dangerouly ill due to this surgery, computerized review of mortality rates, as has been suggested by HCFA, would not have picked up the problem.

The third aspect of our process includes on-site DRG validation, a key element in the new reimbursement proposal This is accomplished by medical record reabstraction, diagnosis coding, recoding and remapping of the DRG by computer. Our teams of nurses, medical records specialists, and physicians routinely reviewed samples of medical records to assure proper DRG assignment. An example of such a correction made was one case filled out as DRG–168, viral pneumonia, with a reimbursement of $6,000. It was identified and ordered changed by the PSRO to DRG–172, as madic bronchitis, which carried a payment of $980, a $5,000 correction. We also find DRG's where the reimbursement should have been higher.

Finally, the PSRO's of New Jersey hear appeals from patients or payers from the DRG assignment or based on the equity of the charges to the DRG in the case of self-pay individuals.

My colleague, Mr. Cherecwich, will now discuss various technical aspects of the review system.

Thank you.

STATEMENT OF ROBERT CHERECWICH, EXECUTIVE DIRECTOR, HUDSON COUNTY PROFESSIONAL STANDARDS REVIEW ORGANIZATION, JERSEY CITY, N.J.

Mr. CHERECWICH. The submission and recent approval by the New Jersey Department of Health——

Senator DURENBERGER. You are down to 30 seconds.

Mr. CHERECWICH. I know. The submission and recent approval by the New Jersey Department of Health of our proposals to formally implement the peer review process within the prospective reimbursement system is indicative of the fact that peer review organizations are a vital and indigenous component of efforts to control total utilization.

Our organizations are at the edge of peer review technology vis a vis our impending implementation of analysis of resource consumption within the patients length of stay through online analysis and standard computer reporting of exceptionally specific utilization elements. The focal point will become utilization of resources within ancillary departments. Such utilization is not only a primary factor contributing to total patient cost, but is a significant contributor to total length of stay.

Data sources for completing designated tasks extend far beyond the presently utilized patient abstract, to comprise the use of sophisticated data sources of which there are three.

First, the Uniform Bill Patient Summary required for completion since January 1, 1981 for all payers, contains case mix and a clinical data as well as patient specific charges. The UB–PS is a logical and necessary extension of the patient abstract.

Second, a New Jersey Department of Health generated data source known as the equalized Y tape, which contains DRG assigned case mix, clinical payer, and physician specific information by cost centers.

Third, standard management reports focusing upon high negative variance DRG groups, defined as characteristics of an environment wherein a hospital's costs and charges substantially exceed reimbursement resulting in a deficit situation, possibly indicative of over utilization.

With these data sources, we will focus upon provider and practitioner specific DRG groupings, establishing norms and standards particularly in the area of ancillary utilization, as well as for overall length of stay.

As an example, the high ancillary resource consumption within a particular DRG, as demonstrated by a physician, which is at variation from the standard as established by his peers, may be indicative of over utilization requiring change in the practice pattern. Also, analysis of high resource consumption will generate the performance of quality review studies in order to determine appropriateness and quality of care.

Heretofore, peer review has focused primarily on the appropriateness of the total day of stay through review of specific charts by qualified physician consultants. Hence, peer review in the prospective reimbursement system in New Jersey will also focus upon, through the addition of the described data sources, ancillary utilization within the day of stay.

Thank you very much.

Senator DURENBERGER. Thank you all very much for getting a lot of information into the system in a short period of time.

As I indicated, your full report will be made part of the record.

[The prepared statements of Mr. Duffy, Mr. Allen, and Mr. Cherecwich follow:]

HEARING
BEFORE THE
SENATE COMMITTEE ON FINANCE SUBCOMMITTEE ON HEALTH
FEBRUARY 17, 1983

PEER REVIEW
WITHIN THE
NEW JERSEY PROSPECTIVE REIMBURSEMENT SYSTEM

BY

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TESTIMONY BEFORE SENATE FINANCE COMMITTEE,

SUBCOMMITTEE ON HEALTH

THURSDAY, FEBRUARY 17, 1983

Mr. Chairman: My name is Dennis Duffy, I am Executive Vice President of the Suburban Medical Review Association in Kenilworth, N.J. My associates are Marc Allen, Executive Director of the Essex Physicians' Review Organization in South Orange, and Robert Cherecwich, Executive Director of the Hudson County PSRO in Jersey City.

We appreciate this opportunity to express our concern over the proposed reimbursement system's lack of an appropriate Quality Assurance and Utilization review program. As you know, New Jersey has such a review system incorporated into our prospective payment system, and we would like to briefly describe our program.

Our organizations are federally designated PSROs under Public Law 92-603 and designated Utilization Review Organizations under Chapter 83 of Public Law 78 of the Statutes of the State of New Jersey. We perform Medicare review under the Federal statutes and review is performed on all other patients under the state statutes. Our three organizations have approximately 2,900 physician members. Our counties contain three of New Jersey's largest cities, those being Newark, Jersey City and Elizabeth. There are well over two million people, 36 hospitals and approximately a quarter of a million Medicare eligibles in the three counties.

With the passage of the Tax Equity and Fiscal Responsibility Act of 1982 including the Peer Review Improvement Section EPRO, SMRA and HC PSRO are preparing for the implementation of the P.R.O. program by moving toward a merger into an even more cost-efficient administrative structure. We anticipate saving HCFA another 25% of our administrative costs through this corporate merger. One note, since our commencement of total review, our costs to HCFA are close to 50% less than what they were in 1980.

We have been reviewing Medicare patients since 1976 and as of today, have reviewed nearly 600,000 discharges of Medicare patients and 1.2 million patients in total. New Jersey currently has eight PSROs reviewing all patients in approximately 100 hospitals. This combined program reviews 1.2 million cases annually and boasts physician membership of approximately 6,500.

It is well known that the prospective, by the case reimbursement system envisioned by HCFA, changes incentives to hospitals and physicians relative to the delivery of health care. My associate, Mr. Allen, will begin to describe the system we have tailored to perform review under a DRG style payment system.

I would like to take a few minutes to discuss the PSRO/PRO hospital review system. The New Jersey PSROs have made modifications to the Federal review system to accommodate the changed incentives in the delivery of health care and its reimbursement.

Currently there is no incentive for hospitals to keep services to a miniumum because the financing mechanism is based on "reasonable cost" reimbursement for services rendered. The more resources ordered by the physician, the more delivered by the hospital, and the more reimbursement is received.

With price per case prospective DRG reimbursement, the incentive is reversed. The hospital receives a fixed-price-per-case no matter how many resources were consumed. The fear is that needed services may be denied in order to maximize profit within the price-per-case. The important part is to restrict unnecessary services; and to provide only needed services. Only locally-directed peer-review as exemplified by PSRO can grant the assurance that quality care and appropriate use at the hospital setting will occur.

PSRO physicians establish the criteria and standards with which peers review each other's practice patterns. PSRO physicians review each other's cases on a concurrent basis. This has proven to be more timely, fair to patients, physicians, and hospital alike. By contrast, Government and Fiscal Intermediary retrospective data analysis, judged by your own Committee in 1970 to be a failure, simply cannot accomplish the same necessary objectives.

Another fear in a prospective reimbursement system is the lack of attention to quality of care because of the new profit motive. Certain individuals might be tempted to deny necessary services to the aged to maximize reimbursement. Generally, emergency room care is very costly - perhaps a hospital would shut down or reduce such emergency services or costly surgical procedure in favor of those types of cases they can treat most efficiently.

Finally, there is a danger of manipulation of diagnosis coding and DRG assignment to increase reimbursement beyond what might be expected. This has been referred to as "DRG Creep."

We utilize nurse review coordinators and physician review advisors who review hospital cases on a daily basis.

The process includes review of necessity of admission and continued stay, as well as review for use of hospital services - such ancillary services as surgery, laboratory, X-ray, therapy, drugs, etc. This combined utilization and quality assessment approach on a concurrent basis clearly identifies unnecessary services and admissions and allows us to correct deficiencies quickly.

Upon admission, the nurse coordinator reviews the case using criteria developed by PSRO physicians. This criteria called "Severity of Illness -- Intensity of Service, qualifies the patient's degree of illness or problem and, measures the amount or level of services required to be rendered.

If the admission is questioned, that is, if it fails to meet the criteria, the case is referred to the physician reviewer for determination after discussion with the attending physician. The reviewer will then approve or deny the case based upon his clinical judgment. Critics say this peer interaction could be replaced by fiscal-intermediary computer analysis. This, simply, is not the case. Our concurrent peer review is more palatable to the Medicare beneficiaries due to its timeliness, and to the attending physicians who appreciate the direct peer contact instead of computer and clerical analysis.

EPRO, HC PSRO and the SMRA have recently demonstrated in 1981-82 comparisons, reductions in admissions or the rate of increase of admissions as well as length of stay in all programs.

As second aspect to our review process addresses Quality of Care. This is important because of the fear of deprivation of the quality of medical care due to the new reimbursement incentives. We perform Quality Review Studies directed by physician specialty committees on topics which are either known or suspected problems. One example was a study on Bilateral Cataract Surgery. Ophthalmologists set the criteria and reviewed over 700 charts during the study and re-study. One physician was found to be performing simultaneous bilateral cataract surgery, which presents high risk of infection and potential blindness to both eyes. The committee required the physician to stop performing this type of procedure.

Since no one died or became dangerously ill due to his procedure, computerized review of mortality rates would not have picked up the problem.

My collegue, Mr. Cherecwich, will now discuss various technical aspects of the review and analysis system. Thank you.

The submission and recent approval by the New Jersey Department of Health (NJDOH) of our proposals to formally implement the Peer Review Process within the Prospective Reimbursement System is indicative of the fact that Peer Review Organizations are a vital and indigenous component of efforts to control total utilization.

Our organizations are at the edge of peer review technology vis a vis our impending implementation of analysis of resource consumption within the patients length of stay through on-line analysis and standard computer reporting of exceptionally specific utilization elements. The focal point will become utilization of resources within ancillary departments. Such utilization is not only a primary factor contributing to total patient cost, but is a significant contributor to total length of stay.

Data Sources for completing designated tasks extend far beyond the presently utilized patient abstract, to comprise the use of sophisticated data sources of which there are three.

First, the Uniform Bill Patient Summary (UB-PS) required by NJDOH for completion since January 1, 1981 for all payors, contains case-mix and clinical data as well as patient specific charges. The UB-PS is a logical and necessary extension of the patient abstract.

Second, a NJDOH generated data source known as the equalized - Y tape which contains DRG assigned case-mix, clinical, payor, and physician specific information by cost centers.

Third, standard management reports focusing upon high negative variance DRG groupings, defined as characteristic of an environment wherein a hospital's costs and charges substantially exceed reimbursement resulting in a deficit situation, possibly indicative of over-utilization.

With these data sources, we will focus upon provider and practitioner specific DRG groupings, establishing norms and standards particularly in the area of ancillary utilization, as well as for overall length of stay.

As an example, high ancillary consumption within a particular DRG, as demonstrated by a physician, which is at variation from a standard as established by his peers, may be indicative of over-utilization requiring a change in the practice pattern. Also, analysis of high resource consumption will generate the performance of quality review studies in order to determine appropriateness and quality of care.

Heretofore, peer review has focused primarily on the appropriateness of the total day of stay through review of specific charts by qualified physician consultants. Hence, Peer Review in the Prospective Reimbursement System will also focus upon, through the addition of the described data sources, ancillary utilization within the day of stay.

On behalf of my colleagues, thank you for the opportunity to appear before your committee.

SUBURBAN MEDICAL REVIEW ASSOCIATION

OVERVIEW AND HIGHLIGHTS OF THE 1983 PROPOSAL

The proposal addresses all pertinent areas and functions of the SMRA's operation. It houses a description of the management operation of the corporation as well as the actual review system functions.

The plan demonstrates the SMRA's ability to perform DRG analysis, utilization review and quality assurance at a very reasonable cost. There are a few areas which will rely on hospital and Department cooperation. One particular area is the analysis section, where the SMRA must receive historic UB-PS data tapes and Hospital DRG Management Reports in order to deliver the analysis proposed.

A. The Review System - The Utilization Review function is performed by the use of a highly concentrated Admission Review Program which will look at all admissions except normal delivery and healthy newborns.

The Continued Stay Review Program will use the cyclic review system, with review being assigned for up to every five working days.

The Retrospective Review, or our Quality Review Study Program, will require two individual hospital studies and three areawide studies per year.

The system will also perform occasional special studies as deemed necessary. Special psychiatric studies have and will be performed. In addition, the SMRA has a Program Impact Section on the Utilization Review Worksheet which is utilized to document Nurse, Social Service and normal Peer Review Interaction.

The SMRA has a comprehensive program of Discharge Planning which is coordinated with the individual hospital personnel.

B. Monitoring and Oversight

The proposal demonstrates in detail the SMRA monitoring methodology which began with use of our delegation criteria and assessment of the area hospitals. This process continues through two formal monitoring visits at each hospital each year. The delegated hospitals are given the responsibility of performing review in accordance with our systematic requirements, and, if they continue to meet our compliance standards, they may retain their delegated status, according to our Monitoring and Delegation Plans. If these institutions do not perform well, they become subject to these same delegation criteria for removal of delegation.

The monitoring program has a simple basis; through the visits to the hospitals, we can identify problems and achieve their resolution through corrective-action plans.

This ongoing process of monitoring manages to keep the system running as smoothly as it should with the desired results.

C. Data and DRG Analysis

The normal Data collection (NJUP) and processing (South Carolina Medical Building) continues, but many DRG/case-mix reports and analysis sets have been completed to satisfy the Department's requests.

Three new sources of data will be used (if SMRA can receive clearance to get them); namely, UB-PS, Y-tape and selected DRG Management Reports. Through these data sources, the SMRA will attempt to analyze and evaluate the DRG system and be able to locate areas for concentration in the future. The analysis will enable the SMRA to evaluate the case-mix system within each hospital with the ability to compare functionally specific data on cost and quality. The Association will be able to perform areawide and individual hospital comparisons which should benefit the Department, Payor and Institution.

1983-84 OBJECTIVES

OVERVIEW

Objectives I, II and VI approach utilization control on an areawide basis. Objectives I and II focus on specific diagnostic-related groupings (DRGs) and Objective VI is aimed at reducing the total acute days of care (DOC) for the Suburban Medical Review Association (SMRA) area. While the *potential* impact of any areawide objective tends to be quite significant, *actual* impact is often more readily achieved on a provider-specific basis. Objectives III and IV and V focus-in on particular DRG, hospital or physician combinations which the SMRA has identified as displaying problematic utilization patterns.

Objective III targets DRGs for which any hospital-specific AALOS exceeds the areawide AALOS for that group by at least one day, or 10%, whichever is greater.

Objective IV focuses on physicians with above-average, casemix-adjusted AALOS.

Objective V establishes another areawide target (reducing medically unnecessary reimbursed days of care) but focuses on hospital-specific physician practice patterns.

Objective VII addresses the appropriateness of the clinical indications for performance of upper G.I. endoscopy in an effort to reduce the number of unnecessary procedures.

Objective VIII focuses on the incidence of misread gallbladder X-rays and/or sonograms in order to reduce the problem and prevent the performance of unnecessary cholecystectomies.

Rev. 2/1/83

QUALITY ASSURANCE PROGRAM SUMMARY

During 1982, the SMRA completed four original Quality Review Studies (QRS) and three reaudits, performed one special study and conducted concurrent quality assurance for four surgical procedures. The following summarizes problems identified, action taken and impact demonstrated, where applicable, as a result of these studies.

1. Quality Review Studies

A-6 Urinary Tract Infection - The original study revealed problems in four major quality areas, as well as with documentaton in physician progress notes. Hospitals were required to conduct continuing-medical-education programs for physicians and inservice training for nursing staff. A reaudit was conducted in the summer of 1982, and impact was demonstrated in the following areas:

	Original Study	Reaudit	% Change
Validation of Diagnosis (100%)	95 %	100 %	+ 100 %
Indications for Catheter Use (100%)	74	88	+ 54
Use of 3-way Foley (0%)	45	6	- 87
Sterile Drainage System (100%)	40	80	+ 67
Antibiotic Use (100%)	78	85	+ 32
Documentation of UTI in Progress Notes (100%)	49	60	+ 22

A-7 Cerebrovascular Accident - A follow-up reaudit in 1982 on CVA indicated impact in the following problem areas:

	Original	Reaudit	% Change
Referral to Rehab Services within 72 hours of admission	84 %	88 %	+ 25 %
Referral to Discharge Planning within 7 days of admission	78	94	+ 73

A-8 Abdominal and Vaginal Hysterectomy - After implementing areawide and hospital-specific corrective-action plans, the following impact was noted at reaudit:

	Original	Reaudit	% Change
Surgical Indications (100%)	98 %	100 %	+100 %
Post-op Morbidity (0%)	26	15	- 42
Urinary Tract Infection (0%)	9	4	- 55
Wound Infection (0%)	4	1.3	- 67
Use of P.A.T.	88	93	+ 42
Length of Stay:			
. Pre-op (all cases)	1.6 days	1.7 days	
(elective)	1.4 days	1.1 days	-.3 day
. Total (all cases)	9.2 days	9.3 days	
(elective)	8.9 days	8.0 days	-.9 day

A-9 Permanent Pacemaker Insertion- Original study completed March 1982. Problems were identified in three major areas: 1) inappropriate indications for 5% of pacemaker implants; 2) high post-operative length of stay; and 3) lack of post-operative chest films. Incidental findings included inaccurate coding due to incomplete diagnoses recorded on the face sheet, and excessive variation between actual pacemaker cost (manufacturer charges) and hospital markup (patient cost). A reaudit will be conducted in March 1983, and will focus on the above-noted problems.

A-10 Acute Myocardial Infarction - Original study completed March 1982. Problems identified in the following areas: 1) inappropriate diagnosis of M.I. in 4% of cases; 2) high mortality rate; 3) inappropriate utilization of monitored beds. Hospitals were specifically asked to address the issue of appropriate bed utilization to alleviate bed shortages for critically ill patients. A reaudit will be conducted in April 1983, and will focus on the foregoing problems.

A-11 CAT Scans of the Head - Original study completed May 1982. No problems were reported on appropriateness of indications for head CAT scans. However, problems were identified regarding timely performance of scans and over-utilization of brain scans and EEGs. A reaudit will be conducted in early 1983 to monitor reduction in the time period for performance of CAT scans, to determine decreased utilization of brain scans and to assess continued appropriateness of indications for CAT scans.

A-12 Upper G.I. Endoscopy - Original study completed November 1982. Identified problems pertain to lack of indications for performance of endoscopies and lack of an upper G.I. series prior to endoscopy. A reaudit will be conducted during the latter part of 1983.

2. Special Study - Respiratory Complications

An in-depth study on the increasing post-op respiratory complication rate in cholecystectomy patients was conducted by SMRA physician and nurse reviewers during 1982. The study revealed a 12% documented rate of post-op complications (pneumonia, pneumonitis and atelectasis) occurring in high-risk patients.

Corrective action included the performance of continuing-education programs for physicians to instruct them in proper identification of high-risk patients, performance of pre-op pulmonary evaluations and prompt delivery of respiratory therapy when clinically indicated.

Concurrent monitoring of all cholecystectomy cases will be conducted during January and February 1983 to ascertain the effectiveness of the educational sessions and the decrease in the respiratory complication rate.

3. Concurrent Quality Assurance

A. The SMRA conducted a six-month concurrent quality assurance study addressing the medical necessity for performance of four major procedures: cholecystectomy, abdominal hysterectomy, vaginal hysterectomy and permanent pacemaker insertions. All cases were found to be compliant with the criteria; it was determined that the procedures were being performed appropriately and were medically necessary. However, two cases were identified which noted positive radiologic findings for stones, but no evidence of stones was found during surgical or pathological evaluation. A subsequent chart review revealed problems at two hospitals and this issue will be addressed more fully during 1983.

B. In an effort to intensify review in psychiatry, the SMRA recently implemented a formal quality assurance psychiatric review program. Criteria were developed encompassing admission appropriateness, quality of care and identification of inappropriate lengths of stay. Specifically, the criteria addressed: 1) justification for admission; 2) treatment plan; 3) frequency and appropriateness of medications; 4) indications for ECT; and 5) administration of lithium carbonate.

To date, data have identified the inappropriate use of multiple psychiatric medications as a major problem area. Further investigation and corrective action will be taken by the SMRA in 1983.

Quality assurance plans for 1983 include an in-depth assessment of the quality of care rendered by mobile intensive care units (MICU) for patients with cardiac arrest. An areawide quality review study will begin in January 1983.

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MEDICAL DIRECTOR

February 1983

Hospital

, New Jersey

Dear Dr.

During a recently completed areawide quality review study on "Upper GI Endoscopy", the Suburban Medical Review Association identified a possible aberrant practice pattern at your institution. Analysis of the Physician Profile revealed that the cases belonged to Physician

In accordance with Sections 1155 and 1160 of the Social Security Act, SMRA has overall responsibility for the identification of unusual patterns within the area and to insure that care provided is consistent with professionally recognized standards. Therefore, the SMRA Board of Trustees has requested that Physician meet with an Ad Hoc Peer Committee consisting of two members of the Gastroenterologist Subcommittee and the SMRA Medical Director. The purpose of the meeting will be to discuss the findings of the quality review study and the appropriateness of the indications for the procedure. It would be worthwhile to have available some of the records for suitable discussion.

In order to set up a mutually convenient meeting time please ask Physician to contact Dr. Charles Dooley, SMRA Medical Director, at his office at 233-7878 by March 4, 1983. Usually, Wednesday afternoons appear to be convenient for most physicians.

Thank you for your continued cooperation.

Sincerely,

David Kaufman, M.D.
Chairman, Endoscopy
Subcommittee

Charles E. Dooley, Jr., M.D.
Medical Director

cc: President of Medical Staff
Administrator

CONCURRENT REVIEW ACTIVITY SUMMARY

1. Acute Length of Stay

a. Medicare - The acute ALOS for Medicare patients for the period January through November 1982 was 11.3. For the year 1981, the acute ALOS was 11.9.

	Discharges	Acute Days	Acute ALOS
1981	25,895	308,608	11.9
1982	24,755	280,840	11.3

To date, this has resulted in an average reduction of 5%. For specifics, refer to Exhibit I.

b. Medicaid - Non-delegated review of Medicaid patients started with the admissions of February 1982. Available data show a reduction in ALOS of 6.9%.

	Discharges	Acute Days	Acute ALOS
1981	6,033	38,676	6.42
1982	5,455	32,618	5.98

For specifics, refer to Exhibit II.

c.*Blue Cross of New Jersey - The acute ALOS for Blue Cross of New Jersey patients for the period January through November 1982 was 5.6. For the third and fourth quarters of 1981, the acute ALOS was 6.0.

	Discharges	Acute Days	Acute ALOS
1981	11,191	67,478	6.0
1982	28,681	161,365	5.6

For specifics, refer to Exhibit III.

d.*Commercial/Other - The acute ALOS for Commercial/Other patients for the period January through November 1982 was 5.8. For the third and fourth quarters of 1981, the acute ALOS was 6.4.

	Discharges	Acute Days	Acute ALOS
1981	8,926	56,975	6.4
1982	26,202	152,385	5.8

For specifics, refer to Exhibit IV.

2. Monitoring - Formal and informal visits were conducted semi-annually at all seven acute-care hospitals. The areas monitored were:

- Concurrent review activities
- Appropriateness of Review Coordinator and Physician Advisor decisions
- Discharge planning activities
- Certification procedures
- Quality review studies
- Data quality and DRG validation

* Due to incompatible comparison data because of non-Federal phase-in, no days of care report is being noted at this time.

As a result of these visits, the SMRA de-delegated the Physician Advisor function of the review system at Hospital 605; and rescinded the probationary status for the Physician Advisor function at Hospitals 601 and 606.

3. DRG Appeals and Reconsiderations - January through December 1982

a. DRG Appeals

DRG Upheld	Reversed Charges	Rate Modified	Total Hearings
38	11	2	51

b. Reconsiderations

Hospital Decision Upheld	Hospital Decision Modified	Total No. Cases
18	7	25

ESSEX PHYSICIANS' REVIEW ORGANIZATION - ESSEX COUNTY URO

UTILIZATION REVIEW PROCESS UNDER CHAPTER 83, L. 78

I. 1982 UR Data

The table below displays EPRO's UR statistics from January through December, 1982 for Medicare and Non-Federal patients, and from March through August, 1982 for Medicaid patients (EPRO's non-delegated Medicaid review program was implemented on March 1, 1982).

PAY SOURCE	DISCHARGES	CERT DOC	CERT ALOS	TOTAL DOC	TOTAL ALOS	DENIALS
MEDICARE	35383	442009	12.5	471463	13.3	1350
MEDICAID	18598	112636	6.0	118788	6.3	980
NON-FEDERAL*	58513	375289	6.4	377386	6.5	443

* The Non-Federal data reported above reflects only those hospitals under DRG review prior to October 1, 1982 - 12 of the 16 Essex County acute care hospitals. Nine hospitals were implemented for DRG review in March, 1981, two hospitals were implemented in June, 1982 and one in July 1982. The remaining four hospitals were implemented after October 1, 1982.

II. Impact

A. Medicaid

EPRO reports a significant reduction in Medicaid discharges and days of care since the implementation of non-delegated review March 1, 1982. The display below clearly demonstrates the decreases in discharges, certified days of care, total days of care and costs per diem for the six month periods of March - August 1981 and 1982.

YEAR	DISCHARGES	CERT DOC	CERT ALOS	TOTAL DOC	TOTAL ALOS	DENIALS	TOTAL COST @$300/CERT DAY
1981	20343	123736	6.0	126597	6.2	350	$37,120,800
1982	18598	112636	6.0	118788	6.3	980	$33,790,800
CHANGE	-1745	-11100	-	-7809	+.1	+630	$-3,330,000

B. Medicare

A comparison of EPRO's UR data for Medicare appears below. The time periods being compared are January through September, 1981 and January through September, 1982.

YEAR	DISCHARGES	CERT DOC	CERT ALOS	TOTAL DOC	TOTAL ALOS	DENIALS
1981	34015	423199	12.4	454155	13.4	1342
1982	35383	442009	12.5	471463	13.3	1350

C. Non-Federal

A comparison of EPRO's UR data for Non-Federal patients appears below. The time periods being compared are March through September 1981 and March through September, 1982. Although only 9 of Essex County's 16 acute care hospitals are reflected in this display, it must be noted that these time periods were chosen as a basis for comparison because the nine hospitals were implemented for DRG review on March 1, 1981 while the other 7 hospitals were implemented sporadically as part of EPRO's "phase-in" plan for DRG implementation.

YEAR	DISCHARGES	CERT DOC	CERT ALOS	TOTAL DOC	TOTAL ALOS	DENIALS
1981	40876	249229	6.1	249854	6.1	183
1982	42333	267655	6.3	268734	6.4	231

D. Conclusion

EPRO's non-delegated Medicaid review program showed significant impact in 1982. Major reductions were reported in discharges, and certified and total days of care. As a result of these reductions, EPRO's non-delegated review program reports a savings of more than $ 3 million to Medicaid for the six month period studied.

Although the 1981/1982 statistics reported for Medicare do not show reductions in the UR categories displayed, the actual difference in numbers reported is insignificant. In 1982,EPRO maintained the proper utilization patterns set in 1981.

EPRO is not able to report any reductions in the 1982 statistics displayed for Non-Federal patients. However, the problem is being addressed and improvement in UR performance is anticipated in 1983.

III. AREAWIDE IPPB RESTUDY - IMPACT

Early in 1980, EPRO was invited to participate in a multi-PSRO study of IPPB Therapy coordinated by the Colonial Virginia Foundation for Medical Care. The purpose of this study was to determine actual practice patterns across PSROs in the treatment of diseases which could be more effectively or just as effectively treated with hand-held nebulizers, incentive spirometry and chest physiotherapy.

Thirty (30) PSROs participated in the original study representing 28 States, 502 hospitals and 21,477 patients. The data revealed that nationwide 58% of the cases studied did not meet the criterion for use and 40% of the cases did not meet the criterion for continued usage of IPPB.

Thirteen (13) Essex County hospitals participated in the original study which involved 432 cases. Essex County results revealed an excess number of orders for IPPB as well as prolonged duration of treatment based on predetermined criteria.

EPRO initiated a restudy of IPPB Therapy on June 23, 1982. Although two hospitals did not submit the necessary data in the original study and therefore were not represented in the comparison totals, there was a significant (68%) decline in the number of patients admitted and treatments administered for IPPB in January , 1982 vs. January, 1980. Conversely, there was a significant (52%) increase (comparing the same time frame) in the number of patients receiving incentive spirometry, indicating a trend away from IPPB toward other forms of respiratory therapy.

Comparison of data collected from respiratory therapy departments of the nine (9) hospitals also reflected significant impact.

One hospital with a 92% variation rate for Indications and a 100% variation rate for Duration of Treatment in the original study discontinued using IPPB Therapy as a result of findings from the original study. As a result of the restudy, another hospital stated that the use of IPPB Therapy would be phased out in the facility.

#/% Variations

	Original	Restudy
Criterion I (Indication)	224/63	51/30
Criterion II(Duration)	214/60	50/29

Each of the nine Essex County hospitals participating in the restudy was asked to retrieve 25 patient records in which IPPB treatment was given with or without accompanying chest physiotherapy between January 1, 1982 and April 30, 1982. Records were chosen by random sampling, excluding patients under age 15. Two criteria from the original study were restudied: Indication for IPPB and Duration of Treatment.

It is estimated that the total cost savings realized by Essex County hospitals as a result of EPRO's IPPB Therapy study amounted to more than $94,500.

IV. DRG Appeals

In 1982, EPRO processed 295 appeals including 161 medical necessity appeals and 134 DRG-related appeals.

The activity can be summarized as follows:

•Medical Necessity Appeals

	TOTALS	UPHELD	REVERSED	MODIFIED
MEDICARE	30	14	11	5
MEDICAID	120	58	46	16
NON-FEDERAL	11	9	1	1

•DRG-Related Appeals

	TOTALS	UPHELD	CHANGED
DRG ASSIGNMENT	42	32	10
EQUITY	92	6	86

ESSEX PHYSICIANS' REVIEW ORGANIZATION, INC.
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ACUTE MYOCARDIAL INFARCTION

STUDY SUMMARY NARRATIVE

Essex Physicians' Review Organization (PSRO Area IV) conducted its first AreaWide Medical Care Evaluation Study in 1978 with 12 hospitals participating.

Facilities with over 10,000 admissions per year were requested to retrieve 50 charts and those with under 10,000 admissions per year, 25 charts were requested. These charts were pulled consecutively starting from January 1, 1977 with the principal diagnosis of Acute Myocardial Infarction.

The total number of charts retrieved was 425 with 5 hospitals submitting 50 charts and 7 hospitals submitting 25. A total of 217 physicians managed these 425 patients.

The enclosed statistical analysis of the data collected reveals that the modal age was 65 and over in all cases except 1 hospital #103, in which case, it was between 50-64. 52.7% were over 65 years of age, 35.3% were between 50 and 64, 11.5% were between 35 and 49. Hospitals #107 and 115 accounted for the 2 patients between 20 and 34 with 0.5%.

As revealed in Table #2, the overall mortality rate was 25.2%, 20% occurring in the Intensive Coronary Units and 4.2% in the room. Out of a total of 425 patients, 107 died - 89 deaths in ICU and 18 in the room. Hospital #101 had the highest death rate of 38% and Hospital #110, no deaths. Further investigation was done in Hospital #110 which caused a delay in the final summary results. The next lowest death rate was 12% occurring in Hospital #116. Most of the deaths were justified by the Hospital Audit Committees. The highest ICU death rate was again in Hospital #101 with 30%, and the lowest in #116 with 8%. Hospitals #101, 117, 102, 103, 107, 111 and 115 had the highest death rate.

Analysis of the charts meeting the element in the 100% standard shows that the lowest compliance was in one specific area- namely, instructions to patients on discharge. Hospital #'s 111, 115, 113, 103 and 117 ranged between 92% and 86.6%. The lowest was Hospital #116, with 72.0%. The average % of cases meeting the 100% standard was 85%.

An enclosed explanatory guide for Tables #4 and 5 should be referred to when comparing these Tables.

16% of all charts met exception and critical management criteria.

Display graphs are shown for Tables #6, 7 and 8. Tables 6 and 7 show the comparative variation rates and #8 shows the average length of stay.

The Average Length of Stay on an overall basis was 16 days. The following tables show a breakdown of the ALOS in 3 different categories:

Under 14 days ALOS = 6.0 days
Between 14-21 days ALOS = 17.5 days.
Over 21 days ALOS = 28.0 days

Total patients in study - 425
Total patients days 6816
Average Length of Stay - 16.0 days

It is important to note that confidentiality has been maintained throughout this project.

ESSEX PHYSICIANS' REVIEW ORGANIZATION, INC.
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PSRO SUB AREA WIDE MCE STUDY #1/1978

"Acute Myocardial Infarction"

SUMMARY OF INFORMATION ITEMS

1. Total Hospitals Participating in Study ------------------ 12
2. Total Patients in Study -------------------------------- 425
3. Total Physicians in Study ------------------------------ 217
4. Age Range of Patients ---------------------- (see Table #1)
5. Total Male Patients ----------------------------------- 289
6. Total Female Patients --------------------------------- 136
7. Length of Stay (including Deaths) ----------- (see Table #8)

   Total patients staying under 14 days -------- 117

   Total patients staying over 21 days -------- 88

   Total patients staying 14 - 21 days -------- 220

   Total patients signing out AMA -------- 6

8. Deaths --- (see Table #2)
9. Percentage of cases Meeting the Criteria ----- (see Table #3)
10. Percentage of Variations/Justified ----------- (see Table #4)
11. Comparative Variation/Non Justified Rate ----- (see Table #5)
12. Comparative Variation Rate, Display (Pattern)-(see Table #6)
13. Percentage of Charts Meeting the Exception and Critical Management---------------------- (see Table #7)
14. Final Summary ----------------------------- (see Table #9)

STUDY SUMMARY NARRATIVE
EPRO AREAWIDE AMINOGLYCOSIDE STUDY

PART A (Tables #1-#3)

The purposes of Part A of the Aminoglycoside study were to 1) determine which antibiotics are used; 2) how extensively they are used; 3) which hospitals use them; and 4) the modes of administration.

There were 666 patients involved in Part A of the study; some of them received more than one antibiotic during their hospitalization.

The antibiotics are distributed by hospital in table #1. It is obvious from this display that the use of some antibiotics is limited to a particular hospital. Other antibiotics such as Keflex and Ampicillin are used extensively throughout the county.

In table #2, the data from each hospital is compiled to show every mode of administration used for each drug. Not all the antibiotics are listed here because some were given as drops, soaks or creams.

The total number of patients recorded next to each medication in table #3 is the total number of patients receiving that particular drug. Please keep in mind that some patients received more than 1 antibiotic, therefore making the total amount of patients receiving these drugs greater than the total number of patients in Part A of this study.

PART B (Tables #4-#7)

Table #4 is the criteria set used in the EPRO Areawide Aminoglycoside study. Please refer to this table when reviewing table #5. The aggegate data display, table #5, depicts the overall county performance in the study. Most variations occurred in criteria #IC4 and IC5. Many times the variations for these criteria were easily justified in light of the patients' conditions.

Upon data retrieval by the committee assistant, 346 patients of the 430 patients in the study were receiving aminoglycosides as indicated by the criteria. Of the 84 variations county-wide, 45 were justified after committee review. This means that 10.5% of the charts, had unjustified variations possibly indicating that aminoglycosides were inappropriately used.

Table #6 is a breakdown of ages by hospital. To make the age distribution more meaningful, we have made a special category for children under 1 year of age. The county-wide average age was 54.4. Table #6A is a graph displaying age by hospital using the average age for each hospital from table #6.

Although length of stay was not a criterion, it was felt that this item was important to investigate. The average length of stay for all hospitals was 28.6 days. Table #7 has a breakdown for length of stay in each hospital with total days used.

It is interesting to note the difference of total days used among hospitals using the same number of patients. There were 10,978 days used by the patients in this study.

If you require any assistance in the analysis of this data, please feel free to contact me.

As always, confidentiality has been maintained throughout this project.

SUBAREAWIDE

RE-AUDIT EKG INTERPRETATION STUDY

HOSPITAL ID #	# OF EKGs REVIEWED		EPRO AGREES WITH				EPRO DISAGREES WITH			
	AUDIT	RE-AUDIT	AUDIT		RE-AUDIT		AUDIT		RE-AUDIT	
			#	%	#	%	#	%	#	%
2	42	45	21	50	38	84	21	50	7	16
3	50	50	45	90	43	86	5	10	7	14
5	33	26	25	76	25	96	8	24	1	4
7	41	25	24	59	24	96	17	41	1	4
TOTALS	166	146	115	70	130	89	51	30	16	11

HUDSON COUNTY PSRO REPORT

I. NONFEDERAL PAYORS: IMPACT REPORT*

A. BLUE CROSS OF NEW JERSEY (Calendar Year 1981 and 1982)

QUARTER	ALOS		ALOS CERTIFIED ACUTE DAYS		DENIAL RATE %		DISCHARGES	
	1981	1982	1981	1982	1981	1982	1981	1982
First	----	----	----	----	----	----	----	----
Second	6.8	6.1	6.8	6.0	0.2	1.7	2,544	2,573
Third	6.5	5.9	6.4	5.9	0.5	1.6	2,526	2,443
Fourth	6.5	6.2	6.4	6.1	1.7	1.5	2,514	2,524
Calendar Year	6.6	6.1	6.5	6.0	0.8	1.6	7,584	7,540
Change 1981 to 1982	-0.5		-0.5		+0.8		-44	

*Four hospitals on the DRG System from April 1981 are included.

I. NONFEDERAL PAYORS: IMPACT REPORT

B. BLUE CROSS OF NEW YORK - 1981 and 1982

QUARTER	ALOS		ALOS CERTIFIED ACUTE DAYS		DENIAL RATE %		DISCHARGES	
	1981	1982	1981	1982	1981	1982	1981	1982
First	----	----	----	----	----	----	----	----
Second	6.2	6.3	6.2	6.1	0.1	1.9	857	938
Third	6.5	6.0	6.4	5.7	0.7	1.8	880	962
Fourth	6.4	6.3	6.4	6.1	1.2	2.0	914	892
Calendar Year	6.4	6.2	6.3	6.0	0.7	1.9	2,651	2,792
Change 1981 to 1982	-0.2		-0.3		+1.2		+141	

I. NONFEDERAL PAYORS: IMPACT REPORT

C. OTHER, COMMERCIAL - 1981 and 1982

QUARTER	ALOS		ALOS CERTIFIED ACUTE DAYS		DENIAL RATE %		DISCHARGES	
	1981	1982	1981	1982	1981	1982	1981	1982
First	----	----	----	----	----	----	----	----
Second	6.3	6.4	6.3	6.4	0.5	1.8	2,342	2,521
Third	6.6	6.3	6.6	6.2	0.5	1.7	2,458	2,421
Fourth	6.7	6.9	6.7	6.8	1.3	1.7	2,520	2,334
Calendar Year	6.5	6.5	6.5	6.5	0.8	1.7	7,320	7,276
Change 1981 to 1982	0.0		0.0		+0.9		-44	

II. SUMMARY QUARTERLY IMPACT REPORT

A. NONFEDERAL PAYORS-1982

QUARTER	ALOS			ALOS CERTIFIED ACUTE DAYS		
	BC/NJ	BC/NY	OTHER	BC/NJ	BC/NY	OTHER
First	6.3	6.2	6.6	6.3	6.2	6.5
Second	6.2	6.3	6.4	6.2	6.1	6.4
Third	6.3	6.0	6.3	6.3	6.0	6.2
Fourth*	6.4	6.1	6.6	6.3	6.1	6.6
Calendar Year	6.3	6.2	6.5	6.3	6.1	6.4

QUARTER	DENIAL RATE %			DISCHARGES		
	BC/NJ	BC/NY	OTHER	BC/NJ	BC/NY	OTHER
First	0.9	1.4	1.0	4,562	1,492	4,002
Second	1.5	2.0	1.5	4,874	1,570	4,186
Third	1.4	1.9	1.4	4,616	1,606	4,017
Fourth*	1.8	2.1	2.6	4,663	1,631	4,965
Calendar Year	1.4	1.9	1.7	18,715	6,299	17,170

*ADDITONAL HOSPITAL ENTERS DRG SYSTEM

III. MEDICARE IMPACT REPORT - 1981 and 1982

QUARTER	ALOS		ALOS CERTIFIED ACUTE DAYS		ALOS SNF LEVEL OF CARE		DENIAL RATE %		DISCHARGES	
	1981	1982	1981	1982	1981	1982	1981	1982	1981	1982
First	16.2	15.0	15.3	14.1	0.8	0.7	1.4	3.6	5,472	5,835
Second	15.6	14.4	14.6	13.5	0.9	0.6	2.2	5.0	5,869	6,322
Third	15.4	13.9	14.4	12.9	0.9	0.7	1.4	6.0	5,502	6,038
Fourth	14.9	13.5	14.1	12.8	0.6	0.6	3.3	4.2	5,914	6,416
Calendar Year	15.5	14.2	14.6	13.3	0.8	0.6	2.1	4.7	22,757	24,611
Change 1981 to 1982	-1.3		-1.3		-0.2		+2.6		+1,854	

IV. MEDICAID IMPACT REPORT - 1981 and 1982

QUARTER	ALOS		ALOS CERTIFIED ACUTE DAYS		DENIAL RATE %		DISCHARGES	
	1981	1982	1981	1982	1981	1982	1981	1982
First	7.0	6.8	6.9	6.7	0.9	2.0	4,091	4,112
Second	6.6	6.3	6.6	6.1	0.9	3.7	4,020	3,628
Third	6.6	6.3	6.5	5.9	0.8	4.8	4,341	3,700
Fourth	6.6	5.9	6.5	5.7	1.6	4.2	4,112	3,564
Calendar Year	6.7	6.4	6.6	6.1	1.1	3.6	16,564	15,004
Change 1981 to 1982	-0.3		-0.5		+2.5		-1,560	

Blood Utilization Study

The original study completed in 1981 showed problems in several areas. Hospitals were requested to conduct continuing medical education for physicians regarding blood use. A reaudit was conducted in 1982, and impact was demonstrated in the following areas:

	ORIGINAL	FOLLOW-UP	CHANGE
Packed Red Cells to Whole Blood Ratio (Where below 5 indicates overuse of whole blood)	3.3%	8.4%	+5.1%
Percentage of Patients Transfused	4.4%	5.51%	+1.11%
Number of Transfustion Reactions in One Year	225	125	-100
Number of Hemolytic Reactions in One Year	2	0	-2
Number of Units of Blood Discarded in One Year	622	449	-173
Ratio of Number of Units to Patients Transfused	2.05	2.67	+0.62

Symptoms as Discharge Diagnosis

This 1982 study focused on the patient's being discharged with a symptomatic diagnosis rather than a more definitive diagnosis having been assigned. Corrective action was in the form of physician education and medical coder notification to flag these types of records for peer review.

	ORIGINAL	FOLLOW-UP	CHANGE
Patients Discharged with Symptoms as Primary Discharge Diagnosis	32.2%	20%	-12.2%

Excerpts from: *PSRO IMPACT ON MEDICAL CARE SERVICES: 1981*

(A Report of the 1981 Impact Committee -
March 1982, American Association of Professional
Standards Review Associations)

Alabama Medical Review, Inc., the PSRO for the entire state of Alabama, found unacceptably high acute myocardial infarction mortality rates in thirty hospitals in the state due to delays in placing patients on cardiac monitors and to delays in starting IVs. PSRO physicians met with their peers to discuss these problems and arranged for inservice training and continuing-medical-education efforts. A follow-up audit documented a 71% improvement in timely placement of patients on cardiac monitors and a 62% improvement in the expeditious administration of IVs.

The Central Piedmont PSRO, located in Durham, North Carolina, found that the mortality rate for acute myocardial infarction (AMI) patients in one hospital was 46.7%, a rate deemed much too high by the physicians. As a result, PSRO physicians met with their peers at that hospital, discussed the problems uncovered and arranged for medical education on AMIs. One year later, analyses showed that the mortality rate for AMI in that hospital had been reduced by 37%.

The Nassau Physicians Review Organization in Westbury, New York discovered one physician who, in the judgment of his peers, was providing poor-quality geriatric care. Physicians from the PSRO met with this physician to discuss problems and recommend necessary changes. Failure to correct the problems led to placing this physician on concurrent review and second-opinion consultation. Ultimately, the refusal of this physician to change his inappropriate practice patterns left his peers with no choice but to recommend to the Department of Health and Human Services that this physician be excluded from participation in the Medicare and Medicaid programs. A decision is still pending.

The Iowa Foundation for Medical Care found excessive inpatient dental extractions being performed. All physicians and hospitals involved received written correspondence documenting the problems. Pre-admission certification was implemented for dental extraction admissions. As a result, inpatient dental surgeries were reduced by 95%.

DRG VALIDATION COMPARISON

YEAR	HOSPITAL	CHANGED TO:
1982	LEFT ADNEXAL CYST DRG 319 $1,428.78	ABDOMINAL PAIN DRG 184 $ 900.20
1981	ACUTE MYOCARDIAL INFARCTION DRG 121 $6,672.50	CONGESTIVE HEART FAILURE DRG 132 $2,363.60
1981	HYPERTENSIVE HEART DISEASE DRG 119 $1,910.45	CONGESTIVE HEART FAILURE DRG 132 $2,363.60
1981	CLOSED HEAD INJURY DRG 356 $2,182.58	POST-CONCUSSION SYNDROME DRG 096 $2,400.12
1981	VIRAL PNEUMONIA DRG 168 $6,020.59	ASTHMATIC BRONCHITIS DRG 172 $ 980.89

Senator DURENBERGER. Do any of you have any idea of the cost of peer review as a percentage of a bed day in a hospital?

Mr. DUFFY. In New Jersey, it's ranging for the non-Federal patients that we review, depending on delegation or nondelegation, whether the hospital does it or we do it directly—somewhere between $6 and $12, the high end being the fully nondelegated situation where we would hire the nurses and the doctors. It's a rather reasonable cost when you consider that the normal patient admission is well into the thousands of dollars.

Senator DURENBERGER. That's per admission—$6 to $12 per admission?

Mr. DUFFY. Yes.

Mr. CHERECWICH. It's just about half of what it costs in other parts of the country where only federally funded cases are subject to review. We spread the overhead, so to speak, over all payers and reduce the cost by about half.

Senator DURENBERGER. Where, in your observation, have the problems with DRG system clustered? Or where will you find most of the DRG problems? Is it the marginal admissions, or where do you find them?

Mr. DUFFY. Admission review has become our new push because we are seeing that they do climb when you ignore them. We had a system, due to funding under HEW, where we allowed hospitals to do a lot of focusing out, not reviewing patients, and some of our better hospitals, in the words of reviewing, just went right through the roof again when they stopped reviewing those patients. We have a hospital that for medicare patients in 1981 had something like 2,500. This year they went up to 3,100. Now that's a big jump in that small of a number. It was mainly because they were focusing out a lot of people. So we have gone from the focus system to a 100-percent admission review system. For our HMO contract we have preadmission review, which we may get to before the year is over anyway because of the admission rate problem.

Mr. CHERECWICH. The administration has recognized in their proposal that gamesmanship—I think that was the term—in admitting practices and in DRG assignment are legitimate fears in the program. And we have made our modifications to address those things. I think those are the areas that need addressed. They need to be watched by a peer review process. Length of stay is no longer an issue incentivewise with the DRG reimbursement. But length of stay may be where it ought to be because of 6 or 8 years of review under Federal legislation. So it's the fear of increased admissions, particularly in an overbedded area such as much of our cities have, and the DRG assignment.

Senator DURENBERGER. Can you briefly speak to the HMO issue? As I recall we had somebody from New Jersey and somebody from Maryland speak to the issue last year. And today we had Harvard expressing some concerns about the impact of DRG's on HMO's.

Mr. DUFFY. I was interested in hearing the gentleman from Harvard because the one group that was rabid for a contract with our organization was our local HMO IPA. It is an individual practitioner association. They came to us and said:

> We know that you review our patients under the DRG process in New Jersey but we would like a separate contract where we could be assured that in addition to

preadmission review, which would mean that the physician would call either our office or the office of the HMO, to clear the admission as long as it wasn't an emergency. If there was an emergency there is obviously no problem.

Once the patient is in the hospital, that HMO wants us to review that case everyday.

Senator **Durenberger**. As I recall their testimony, they didn't really care about it. If they went to a DRG system, they would put people in the hospital that they might not otherwise put there, and they wouldn't care how long they stayed there because the HMO wasn't at risk.

Mr. **Duffy**. In a closed panel HMO that may be appropriate. In an IPA, which is the one that will work in a lot of the States because organized medicine can accept that, obviously, they still have to control physicians that can join. Not all physicians are as attuned to a fulltime HMO doctor situation, which doesn't occur in an IPA.

Mr. **Cherecwich**. Let me emphasize that the financial incentive is there in a prospective reimbursement system, but it is, as was stated before, the physician who controls the system. We have found time and time again that when there is change that is required it's perpetuated by peer review in spite of the financial incentive.

Senator **Durenberger**. Senator Bradley.

Senator **Bradley**. Thank you, Mr. Chairman. Just a few questions.

I'm curious as to what you think on how we should treat this monitoring cost. Do you think medicare should help offset some of that cost? Do you think it should be viewed as professional responsibility or cost of doing business?

Mr. **Allen**. I think that the Federal Government set the tone in 1972 relative to the professional responsibility. There are physicians reviewing for you, for us, but they have become accustomed to being paid for it. I believe that physicians will expect to be paid for it at this point. They will be the first to say that prior to PSRO it was a professional responsibility and often done for free, but not so anymore.

In New Jersey all payers participate by statute in the cost of utilization review. That appears to be as it should be. They get return on investments of the outcomes of review.

Senator **Bradley**. All right.

Mr. **Duffy**. Were you referring to the possibility of including the review cost into the DRG rate or the total contribution by medicare?

Senator **Bradley**. The total contribution by medicare.

Mr. **Cherecwich**. Well, what has happened in the last couple of years is that contribution has been minimized which has severely hurt. Two years ago we took 11 percent cut in part 1 of our management and overhead. This year it is being maintained at the same level.

Clearly, the program has not been funded at an adequate level and it has caused problems.

Senator **Bradley**. In New Jersey quality reviews were specified in legislation in very great detail. Do you think that is excessive?

Mr. **Duffy**. You mean specific in the legislation?

Senator **Bradley**. Yes.

Mr. **Duffy**. I don't think you have to be as specific as New Jersey was, but I think it is necessary to put it into the legislation because you never know what will come out in the legislation if it is not at least mentioned in that.

Senator **Bradley**. What elements do you think should be specified?

Mr. **Duffy**. Some measures of quality assurance. At least the requirement that it occur. And as far as I am concerned, that it occur by an outside organization. Obviously, I have a reason for feeling that way. But it should be done that way. Areawide studies that we perform sometimes are very, very interesting. And you find a different attitude when you get physicians sitting down outside of their hospitals, discussing things that go on in their hospitals and other hospitals. They seem to be freed of the harness that might be there. And they do interact very well, in contradiction to what some people said this morning. So I think it should be mentioned, but not in the detail that New Jersey has.

Mr. **Allen**. There has been discussion for years and in this committee for one place relative to what is PSRO for—cost or quality assurance. And I think we have all learned that it is for both. It depends on what the pressures of the day are. Certainly, the changed incentives under your proposed reimbursement system do give rise to a fear of lack of quality or deprivation of quality. Senator Heinz, who is not here today, held hearings along that line

Quality must be a component of any oversight process of your system. Now PSRO, traditionally, through its quality assurance requirements has tracked the Joint Commission on Accreditation of Hospitals Standards for quality assurance. There's not much difference between the two. The only thing is the Joint Commission on Accreditation has always set standards, put them out there, and hope for the best so to speak. Expected that through a once every couple of years visit to a hospital that the standard was being adhered to. PSRO in paralleling the same type of policy relative to quality assurance is there all the time looking at the hospitals, using hospital physicians in groups to set standards and to evaluate each other. So I think the team of the Joint Commission Standard and PSRO capability would serve the reimbursement system, and perhaps reference to those things without much more detail, and would suffice in the regulation.

Senator **Bradley**. One last question. And that is do you feel that the administration's suggestion that the private insurers and Blue Cross monitor the quality makes any sense or the utilization?

Mr. **Allen**. It makes no sense at all. It has failed in the past. And there was a return to the local review. Why did it fail? It fails because, No. 1, I'm not sure insurance companies are tuned into review of medical information. And their computers maintain eligibility and reimbursement information, but not so much medical information. I think that is what has been mentioned in previous testimony.

No. 2, their costs are being reduced all the time for participating in their programs. And, No. 3, their data is bill generated and old and a sample. Our data is medical records generated, concurrent, and at 100 percent.

Senator **Bradley**. How concurrent?

Mr. **Cherecwich**. Our abstract data, which has been our primary source, I would say within 90 days. And in most institutions it may be——

Senator **Bradley**. Within 90 days you are already figuring the data into evaluation of the quality?

Mr. **Cherecwich**. Right. In most institutions.

Mr. **Duffy**. And to take it to the MEDPAR situation, we just received a report, MEDPAR data report, telling us what our length of stay was in 1981. It's doing us a great deal of good obviously.

Mr. **Allen**. We've been through evaluations beyond that criticizing length of stay.

Senator **Bradley**. It's your general feeling that this has worked in New Jersey and should be considered nationally?

Mr. **Duffy**. Every system has its faults. I think that ours can be improved. But I'm sure that if it is allowed to continue, which is another concern that everybody in New Jersey has on the waiver situation with medicare, I think it will turn out to be maybe a little better than the one that the administration is proposing. My biggest concern with the administration's proposal, which has been voiced by everybody, is the outlier situation, which is ludicrous. You know, 90 days is a long time.

So I think with some modifications and growing modifications—fortunately, we have been able to modify it over the last 2 years—I think it will work out. Some hospitals will never love it. Some will do very nicely with it.

Senator **Bradley**. The basic trends you think are sound?

Mr. **Cherecwich**. Absolutely.

Mr. **Duffy**. Better than the old system for sure.

Senator **Bradley**. Thank you.

Senator **Durenberger**. Thank you very much, Senator.

One question, which may be covered some place, but under the New Jersey system can hospitals discount below the DRG?

Mr. **Allen**. I don't know that it is prohibited, but I don't think it is happening.

Senator **Durenberger**. Do you know why it isn't happening?

Mr. **Duffy**. Now every payer has a payer factor which adjusts the amount of money.

Mr. **Cherecwich**. Are you talking about like 48 payers less 5 percent if they pay within a certain period?

Senator **Durenberger**. I'm talking about a hospital cutting a deal with somebody to do a DRG—you know, 95 percent of the DRG over a 1-year period or something like that.

Mr. **Duffy**. I'm not aware of that.

Mr. **Allen**. Rates are set by the Rate Commission. The are the prices per case. Payers—there is no one price per case in New Jersey. That's the one interesting thing. There are both payer factors and hospital mark-up factors, which change and make unique the reimbursement to a hospital for a particular DRG.

Payers in New Jersey for various reasons, participation and uncompensated care and some other things I'm not too familiar with, pay different rates. HMO's pay something less than the standard unit 1.

Senator **Durenberger**. All HMO's pay the same?

Mr. ALLEN. Right. And there are no deals cut.

Senator DURENBERGER. All right. Thank you very much for your testimony. We appreciate it. We will recess until 1:30.

[Whereupon, at 12:37 p.m., the hearing was recessed, to reconvene at 1:30 this date.]

AFTERNOON SESSION

Senator DURENBERGER. The hearing will come to order. And we will start our afternoon with Bernard R. Tresnowski, the president of Blue Cross and Blue Shield Association, headquartered in Chicago, Ill. Your prepared remarks will be part of the record. Thank you for being here.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, CHICAGO, ILL.

Mr. TRESNOWSKI. Thank you very much, Mr. Chairman. I have asked Dick Rogen, vice president of the Massachusetts Blue Cross Plan, to join me. When I am finished with my summary statement he would like to make a brief statement in support of the waiver which Massachusetts achieved over the past year.

We appreciate this opportunity to present our views on the administration's proposed changes in the medicare payment system. We share your concern about rising health care costs and the prospect that, unless action is taken, the medicare program will face severe financial problems.

We agree that redesign of the medicare payment system is warranted if it can improve the incentives for cost containment. However, all of us concerned with medicare's long-term integrity should avoid exaggerated expectations about the amount of program savings which can be achieved through improvement in payment methods. Savings from payment reform alone will not assure solvency.

With respect to payment, our objective is broadly the same as yours: To have payment systems that build in incentives for the efficient delivery of quality health care. Per case prospective payment may be one way to achieve that objective, although it is not the only possible approach. Unfortunately, no one has found the perfect system which builds in all the appropriate incentives while avoiding those which are inappropriate. Accordingly, we would urge the Congress, in embracing a new payment scheme for medicare, to allow for the continued development of other innovative payment schemes by retaining the present waiver authority.

Overall, the Secretary of Health and Human Services' report on prospective payment is a constructive beginning toward restructuring the medicare payment program. However, as might be expected, given the tight deadline, the report is more an outline than a definitive blueprint for reform. Before such a major change is made in the program, much more study and information is needed on several important issues, including:

What will be the impact of the proposed changes on various types of hospitals, such as teaching institutions, public hospitals, small hospitals?

What will be the longer term impact on beneficiaries' access to hospital services? Specifically, will the proposed system inevitably evolve into an indemnity program which requires substantial beneficiary out-of-pocket expenditures?

And, since any system can be manipulated, where is the proposed system vulnerable and, if the incentives cannot be improved, what countermeasures are needed?

And, what key technical points need to be spelled out in a legislative proposal now so that we can better assess the impact of and plan the implementation of a new program?

In summary, it is our opinion that it will take time to evaluate this proposal adequately and to determine whether it is, on balance, better than the present system. Perhaps the diagnosis related groups approach will stand the test of this evaluation; perhaps it will not. In any case, we do not believe that the Congress should rush to enact an incompletely evaluated proposal. And certainly we do not believe an October 1983 implementation date is realistic. For these reasons we recommend that the medicare payment changes that were adopted last year should be continued for the time being.

In our prepared statement we do two things. We outline what we believe the critical objectives for a medicare payment to be, and, second, discuss some of the major strengths and weakness of the administration's proposal.

In commenting on the administration's proposal, we indicate that the proposed system has a number of promising features. We do have some concern about the impact on hospitals of a national average DRG price, the inevitability of there being winners and losers. With regard to the importance of holding to the rule that hospitals cannot charge beneficiaries for any out-of-pocket amounts for covered services other than deductibles and co-insured amounts, we point out the difficulty of staying with this rule if the national average price is arbitrarily established and not sensitive to legitimate hospital differences.

We note some concern about the need to protect against incentives for hospitals to increase payments by manipulating case load and the need to protect against incentives for hospital service unbundling.

With regard to incentives for excessive capital investment, we are also concerned about the effect of capital passthrough under the administration's proposal, especially when the administration has dropped its support for health planning.

And, finally, we note a series of administrative and technical considerations, including how the so-called outliers—that is, the very long-stay cases—will be identified and paid for. It needs clarification of existing beneficiary coverage limitations with cost-based payment, and what type of exceptions and adjustments would be granted to sole community providers.

In summary, we believe the adminstration has taken a constructive step toward the development of incentives for cost effective management of health-care resources. However, adoption of its proposed payment system in its current state of development would be premature.

We believe the Congress should not rush to approve the administration's proposal without thorough evaluation and that implementation this fall would be precipitous.

We appreciate the opportunity to present these views. And with your agreement I would like Mr. Rogen to make a few comments in support of the waiver provision.

[The prepared statement of Mr. Tresnowski follows:]

STATEMENT
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

PRESENTED BY:
BERNARD R. TRESNOWSKI
PRESIDENT

Mr. Chairman and Members of the Committee, I am Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association. The Association is the national coordinating agency for the 102 Blue Cross and Blue Shield Plans in this country. The Plans serve about half of the U.S. population. We provide privately underwritten coverage to about 85 million Americans and serve about another 17 million as fiscal agents or intermediaries for the Medicare, Medicaid and CHAMPUS programs.

We appreciate this opportunity to present our views on the Administration's proposed changes in the Medicare payment system. We share your concern about rising health care costs and the prospect that, unless action is taken, the Medicare program will face severe financial problems. This program is now an integral part of our social system and is vital to the elderly. Unfortunately, demographic projections and revenue forecasts clearly indicate a severe imbalance between Medicare's existing commitments and its capacity to finance them.

This imbalance can be improved in several ways:

- by raising taxes;
- by reducing eligibility;
- by reducing benefits;
- by containing costs for covered services.

None of these approaches is easy, and in all probability, none is adequate alone. Action may be needed in each area to equalize Medicare revenues and spending.

Certainly, redesign of Medicare's payment system is warranted if it can improve the incentives for cost containment. Medicare's original payment method was process rather than outcome oriented and, overall, did not provide adequate incentives for hospitals to contain costs. The changes made under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) introduced some incentives to hold costs below target limits but more can be done to promote efficient management of health care resources.

Nevertheless, all of us concerned with Medicare's long-term integrity should avoid exaggerated expectations about the amount of program savings which can be achieved through improvement in payment methods. Savings from payment reform alone will not assure solvency. And, if payment "reforms" are to be the only focus of efforts to balance the trust fund, the long term integrity of the program and the protection of beneficiaries could be severely undermined. I will have more to say about the potential effect on beneficiary protection later in my testimony.

With respect to payment, our objective is broadly the same as yours: to have payment systems that build in incentives for the efficient delivery of quality health care. Per case prospective payment may be one way to achieving that objective although it is not the only possible approach. Unfortunately, no one has found the perfect system which builds in all the appropriate incentives while avoiding those which are inappropriate. Accordingly, we would urge the Congress, in embracing a new payment scheme for Medicare, to allow for the continued development of other innovative payment schemes by retaining the present waiver authority. We would strongly support allowing states and communities to continue to move to payment systems which differ from Medicare, as long as it can be demonstrated that total Medicare expenditures do not exceed what they would have been under the national system.

Overall, the Secretary of Health and Human Services' report on prospective payment is a constructive beginning toward restructuring the Medicare payment program. The Administration's proposal shifts the focus of payment incentives away from hospital processes toward hospital outputs, that is, cases of treatment. In theory, these incentives could motivate hospitals to examine the cost-effectiveness of how they deliver care and how they consume resources in the process. We favor these kinds of incentives. However, as might be expected, given the tight deadline, the report is more an outline than a definitive blueprint for reform. Before such a major change is made in the program, much more study and information is needed on several important issues, including:

- What will be the impact of the proposed changes on various types of hospitals, such as teaching institutions, public hospitals and small hospitals?
- What will be the longer term impact on beneficiaries' access to hospital services? (That is, will the proposed system inevitably evolve into an indemnity program which requires substantial beneficiary out-of-pocket expenditures?)
- Since any system can be manipulated, where is the proposed system vulnerable and, if the incentive cannot be improved, what counter measures are needed?
- What key technical points need to be spelled out in a legislative proposal now so that we can better assess the impact of and plan the implementation of a new program?

In summary, it is our opinion that it will take time to evaluate this proposal adequately and to determine whether it is, on balance, better the present system. Perhaps the Diagnosis Related Groups (DRG) approach will stand the test of this evaluation; perhaps it will not. In any case, we do not believe that the Congress should rush to enact an incompletely evaluated proposal. And, certainly, we do not believe an October 1983 implementation date is realistic. Medicare Intermediaries still have not yet implemented the changes required under TEFRA for all hospitals and some hospitals will not come under these new limits until September of this year. Such major changes in such a short period of time might seriously disrupt the hospital industry.

For these reasons, we recommend that the Medicare payment changes that were adopted last year should be continued for the time being. We are aware of the limitations and the hazards of these changes, and we urge you to consider relaxation of the Section 223 limits to reduce the potential adverse consequences. We are particularly concerned about the potential impact on "sole source", inner-city and teaching hospitals.

In the remainder of this testimony, we would like to do two things:

1. Outline what we believe the critical objectives for a Medicare payment system to be; and
2. Discuss some of the major strengths and weaknesses of the Administration's proposal.

Payment System Objectives

For Medicare, as for private payors, payment systems should serve several objectives. These include:

- Assurance of the beneficiary's continued access to needed care;
- Maintenance of a quality health care system;
- Cost-effective management of health care resources with rewards for efficiency and penalties for inefficiency;
- Predictability of the amount and timing of payment for both beneficiaries and providers;
- Sensitivity to differences in individual hospital's and community's legitimate needs;
- Administrative economy and feasibility;
- Program requirements and processes that both receivers and providers of care can accept as understandable and reasonable;
- Control on excess capacity; and
- Protection against hospitals surcharging patients.

Clearly some of these objectives can be in conflict with each other. Predictability and administrative feasibility can be at odds with sensitivity to community and institutional needs. Cost control incentives may jeopardize quality and access to care if they are pursued too zealously. We recognize that tradeoffs have to be considered and reasonable compromises reached.

The Administration has recognized most of the objectives outlined above. However, it is not yet clear that its optimism about how well the proposed approach will succeed in meeting these goals is justified.

Comments on the Administration's Proposal

We are still evaluating the Administration's proposal and would like much more information about the data and assumptions on which it is based. Still, our reading indicates that the proposed system has a number of promising features:

- It attempts to assure predictability in the level of government payments to hospitals.
- It should help hospitals manage their resources more effectively and in a manner consistent with their expected Medicare payments.
- It provides rewards for efficiency (but may also reward hospitals that have below average costs for reasons other than efficiency).
- It may require no new data for its operation, although some new data may be required for more effective monitoring of admissions and quality.
- It may recognize case-mix problems more adequately than TEFRA.

These advantages are significant but need to be viewed in the context of potential weaknesses. No payment system is perfect, and any system has inherent incentives that hospitals will naturally respond to but which may not be in the best interest of the program. We need to identify the undesirable incentives in the proposal and the modifications that might be made in response. Although our analysis is not yet exhaustive, we want to indicate a few of the problems we see.

Impact on hospitals of a national average DRG price. We are concerned that paying hospitals on the basis of a nationally determined average price could seriously harm some hospitals, even after regional wage adjustments are made. The "average price" will be more than adequate for some hospitals and will be less than adequate for others. Some hositals with costs which are lower than the national price may not necessarily be efficient; however, they will be rewarded under this system. Other hospitals may be penalized, not because they are inefficient, but because they have special circumstances that the proposed payment method does not take into account. We are concerned that some of the most severely affected hospitals may be essential community institutions, and we would like to see data that assures us that the proposal reflects sufficient sensitivity to justifiable variations in hospital and community circumstances.

Although we favor incentives that will move hospitals to greater efficiency, inefficiency can not be corrected overnight. For that reason and because of our concern regarding local needs, we believe the Congress should consider use of a transition period if a prospective payment system based on national rates is adopted. Hospital-specific DRG rates could be used initially and the uniform national rates gradually phased in. This would give hospitals time to plan and implement constructive management changes that are responsive to the incentives of the new program. A phased-in approach would also reduce the risk of serious and inappropriate disruption in the provision of hospital care to Medicare beneficiaries.

Arbitrariness of determining the national average price. While the Medicare reasonable cost methodology in recent years did employ increasingly stringent limits, there has always been an underlying principle that the reasonable cost of providing services to Medicare beneficiaries would be covered. Such a principle has enabled the program to hold to the rule that hospitals cannot charge beneficiaries for any out-of-pocket amounts for covered services (other than deductibles and coinsurance amounts).

We strongly support the program continuing to hold to the principle of no patient "surcharging." We believe it is the most fundamental protection of beneficiaries against otherwise uncontrollable out-of-pocket medical care costs.

It must be recognized, however, that the yearly calculation of an "average" price per admission may be extremely vulnerable to Federal budgetary pressures and may become subject to continuing and arbitrary "squeezing." If this is the case, hospitals may eventually have a strong argument for billing patients for the balance of unrecovered costs. The vulnerability to manipulation of the average price will depend, to a great extent, on how completely any legislation spells out the methodology for calculation of the price, the methodology for the yearly update of the price, and the mechanism for assuring accountability of the reasonableness of the price.

Incentives for hospitals to increase payments by manipulating case load. Except for a comprehensive capitation payment system or a flat limit on hospital revenues, almost any payment method will tend to stimulate production of whatever unit the payment is based on, whether it be individual services, days of care, or cases. Although the DRG approach contains incentives that could reduce the average length of stay for inpatients and the intensity of the services provided, it could stimulate an increase in the number of admissions. In particular, hospitals could profit by increasing the volume of low cost admissions. This would run counter to existing efforts of third party payers to encourage the use of outpatient care for relatively simple cases, and could ultimately have an undesirable effect on cost and quality of care.

The Administration's proposal recognizes needs for safeguards against inappropriate admission increases, but the process it offers is neither well defined or proven in use. A number of promising methods for monitoring and controlling inappropriate hospital admissions are now being evaluated around the country, but their cost effectiveness and feasibility for Medicare is not clear at this time. But what is clear is that the government should not proceed with a per case program until it has better evidence that it can implement reliable and cost effective utilization controls and quality assurance systems. To work properly, such systems will have to have adequate funding.

Incentives for hospital service "unbundling". Of major concern to us is the inherent incentive for hospitals to accelerate the already alarming trend of what we call "unbundling." That is, hospitals are increasingly billing patients directly for ancillary services (radiology, pathology, therapy) which were formerly included in the hospital bill and reimbursed on a cost basis. Hospitals and physicians can do this by the hospital leasing space in the institution to physicians who then bill patients directly for services under Part B of Medicare. Alternatively, hospitals may transport patients or specimens to be tested to an adjacent office building where the service is provided to inpatients as an outpatient service and billed accordingly.

We see the practice as most unproductive. First, patients, when billed directly, must pay the 20 percent coinsurance and face all the attendant problems of the physician refusing to accept assignment. Second, the movement of the place of service leads to unproductive use of existing hospital capital and generates more capital (outpatient) expenditures.

This unbundling phenomenon has major implications for almost any prospective system. If the trend accelerates, or even just continues, the package of services the DRG-fixed rate of payment is actually purchasing may not look at all like the package of services that hospitals provided when the rate was initially calculated. The Medicare program could end up paying twice for services; once under the DRG rate as an all inclusive inpatient service and under Part B as an outpatient service.

We would further note that these incentives could lead to changes which cannot be "backed away from" through future corrections in the payment system. They are fundamental changes in the way we deliver health care services involving major capital commitments which obligate the delivery system to long-term financing costs.

Incentives for excessive capital investment. We are also concerned about the effect of the capital pass-through under the Administration's proposal. Many see capital investment as driving health care costs. Moreover, capital costs comprise a significant portion of current payments to hospitals and this should not be overlooked.

We do not want a payment approach that encourages investment that leads to unneeded use of services. Nor do we want a method that promotes competitive capital investment without regard for total community resource needs.

We wish to stress that our concern with the capital issue is broader than the amount added directly to the payment rate. Capital expenditures today generate operating costs tomorrow. It has been argued that increased operating costs associated with new capital will not be "passed through" in the DRG rate. Hospitals, however, can recover these new operating costs to the extent that they can increase the volume of cases.

We recognize that the Administration is concerned about excluding capital costs from the per case payment. As one safeguard, we believe that continued federal support for health planning is important to help counterbalance potential incentives for both facility expansion and inequitable resource distribution.

Incentives affecting the quality of care. Under retrospective reimbursement we have experienced incentives for excessive care; under prospective payment we may provide incentives for insufficient care through premature discharge, inadequate testing, and other shortcuts. The professional instincts of hospitals and medical staffs will go a long way to safeguard the quality of care. However, tensions will arise over the limitations of price for those cases which cost the hospital more than allowed for under the DRG payment. This needs to be understood and represents another reason to base the DRG payment, at least in the initial years, on an institution's own cost experience.

Some of the issues discussed above are considered in the Administration's report. However, the report seems to us to be overly optimistic about the quality of current evidence and its own analysis on these issues. We believe the Administration should share with the public the information, estimates and models that it has used in developing the payment proposal. This would permit more extensive and objective evaluation of the proposed system. We need, in particular, a much better sense of which hospitals will be adversely affected and to what extent.

Incentives affecting technological and service innovation. Although the proposed system might stimulate innovations that reduce costs and slow the premature spread of inadequately tested technologies, it might have negative affects as well. In particular, it could discourage investments and stifle innovations that would improve health status at initially higher cost. Under a prospective system, Medicare might need a mechanism to identify and pay for technologies that could be discouraged despite legitimate need because payments were not adequate to encourage investments in their development.

Administrative and Technical Considerations

The successful implementation of this proposal (as with any other payment system) will rest on technical details and the skills of the Intermediary. As it stands, the specific provisions necessary to understand fully the operation and impact of the proposed system are not sufficiently defined in the Administration's report. For example, a hospital's revenue would vary significantly depending on the mathematical calculation used to determine the national average price; however, the proposal is deliberately silent about the approach that will be taken. If the determination of the price is totally unaddressed in legislation, calculation of the national average price would become dependent on an arbitrary decision of the Administration.

Another unknown is how "outliers" (that is, very long-stay cases) will be identified and paid for. The definition of "outliers" and how they are reimbursed may have a major impact on the distribution of revenue to various kinds of hospitals.

Clarification is also needed concerning reconciliation of existing beneficiary coverage limitations with case-based payment. For instance, we do not know whether the patient who exceeds current program limits on days of care would be billed for the balance of his stay or whether the case payment approach contemplates full payment regardless of benefit period.

In addition, the Administration's proposal does not indicate what types of exceptions and adjustments would be granted to sole community providers. Nor is it clear that the proposal deals adequately with the unique problems of small hospitals. These hospitals often have a small number or no cases of a given type in one year and larger numbers in the next; this wide swing in case-mix is likely to result in wide swings in revenue which may have little to do with efficiency.

Although one objective of the Administration's proposal is simplified hospital reporting requirements, we question how much simplification can be achieved. Costs will still have to be determined for capital and medical education, and overhead will still have to be apportioned to support reasonable cost payments for outpatient and certain other hospital-based providers (home health agencies and skilled nursing facilities). In addition, the utilization and quality monitoring functions alluded to in the Administration's report will depend on data collection. Obviously, substantial reporting requirements will still be necessary.

Finally, the transition to any new system is a major undertaking. The current TEFRA regulations are effective for hospital accounting periods beginning on or after October 1,1982. The proposed DRG system is to replace the current system and to become effective at the beginning of hospitals' accounting periods on or after October 1, 1983. This schedule means an unprecedented and intensive workload if the

Intermediary, the Health Care Financing Administration and hospitals are to meet the educational and implementation tasks associated with both the current and the proposed system. This is a major practical drawback to the Administration's proposal. It is also important to note that this demanding transition will require that adequate resources be budgeted for it.

Conclusions and Directions

To summarize, we believe the Administration has taken a constructive step toward the development of incentives for cost effective management of health care resources. However, adoption of its proposed payment system in its current state of development would be premature. There are two bases for this conclusion.

First, many serious questions still exist about how the proposed incentives would affect total Medicare expenditures, quality, beneficiary access, and community resource allocation. The Medicare program has multiple objectives that must be kept in mind as we assess reform of its payment system. There is a pressing need for more conceptual development, more data, more modeling of effects, and more evaluation of TEFRA's impact. The time needed to do this work properly and to make appropriate modifications should not be underestimated.

Second, major changes in Medicare payment policy were made just last summer. It is not prudent to make another major change in the program so soon.

For these reasons, we believe the Congress should not rush to approve the Administration's proposal without thorough evaluation and that implementation this Fall would be precipitous. Given this recommendation against immediate change, we must again cite our concern with TEFRA's payment limits and suggest that you consider the effects that these limits may have on key hospitals and their patients.

Again, we appreciate the opportunity to present our views.

Senator **Durenberger**. Mr. Rogen, welcome. You may proceed.

STATMENT OF RICHARD ROGEN, VICE PRESIDENT, BLUE CROSS OF MASSACHUSETTS, INC.

Mr. **Rogen**. Thank you.

Blue Cross in Massachusetts implemented a prospective hospital reimbursement system for its private business on October 1 of 1981. One year later, this Blue Cross system was extended to all public and private payors in Massachusetts. This came with support from all sectors of the community. State legislation was passed and Federal waivers were obtained to extend this system, as I said, to all payors.

This testimony will make five major points based on that particular experience.

First, although the Health Care Finance Administration' proposal is based upon prospectively determined rates, it is still based on units of service as a vehicle for payment. The incentives to increase admissions remain basically as they were under cost reimbursement in that higher units of service and more costly units of service will provide greater revenue to the hospital. What is lacking in HCFA's proposal are strong positive incentives for hospitals to reduce admissions or shift patients from inpatient to outpatient settings.

Second, Blue Cross of Massachusetts has made a significant commitment to enroll medicare beneficiaries in our HMO's. For example, the Fallon Community Health Plan, a Blue Cross partnership HMO, has enrolled 6,500 medicare beneficiaries and has reduced the days per thousand from 4,400 days to 1,910. Blue Cross of Massachusetts is therefore concerned that relative to HMO reimbursement under DRG's, the DRG system must be compatible with HMO's.

Third, we suggest that any particular reimbursement system will have opportunity for improvement. Such improvements are best discovered through experiments. We are therefore asking that the Secretary's power to conduct demonstration experiments be continued. This would allow all payor experiments such as in Massachusetts and New York to proceed while HCFA is moving forward with its medicare only system.

Fourth, we share the concern of all private sector insurance carriers that the structure of HCFA's DRG system has a potential for major cost shifting to other payors. Two principles must be adhered to: One, a fair and equitable rate of payment must be set, and, two, the hospitals must operate within that level of reimbursement for medicare beneficiaries.

Last, the legislative proposal to change medicare should be sufficiently flexible to allow successful State or regional reimbursement programs to continue. For example, we believe it is reasonable to continue our activities in Massachusetts and other waiver States. Obviously, a State system different from HCFA's should continue only if it is producing better results than what the HCFA medicare only system is capable of doing.

In our program we have guaranteed a rate of increase of 1.5 percentage points below the national average. The current projections for 1983 show that actual savings for HCFA will be even greater than that.

So, in summary, we applaud the prospective rate setting move. However, we stress that there has to be flexibility, and that the DRG concept should be considered in light of the five points that we have made today. I thank you for your time.

[The prepared statement of Mr. Rogen follows:]

STATEMENT OF
RICHARD J. ROGEN
VICE PRESIDENT, BENEFITS ADMINISTRATION
BLUE CROSS OF MASSACHUSETTS, INC.

Good afternoon Senator Durenberger and Members of the Subcommittee. I am Richard J. Rogen, Vice President, Benefits Administration at Blue Cross of Massachusetts. I am here today to testify along with the Blue Cross and Blue Shield Association on the subject of the Health Care Financing Administration's proposal to implement a Prospective Hospital Reimbursement System.

Blue Cross of Massachusetts implemented a Prospective Hospital Reimbursement System for its private business on October 1, 1981. Then one year later, this Blue Cross prospective reimbursement system was extended to all public and private payors. With broad community support including business, commercial insurors, the Massachusetts Hospital Association, the Massachusetts Medical Society, and the Governor of Massachusetts, state legislation was passed and federal waivers obtained to extend this system to all payors on October 1, 1982.

This testimony will make five major points based on our experience.

First, although the Health Care Financing Administration's (HCFA) proposal is based upon prospectively determined rates, it still results in payment by unit of service. The incentives to increase admissions remain basically as they were under cost reimbursement in that higher units of service and more costly units of service will provide greater revenue to the hospital. What is lacking in HCFA's proposal are strong positive incentives for hospitals to reduce admissions, or shift patients from inpatient to outpatient settings.

The prospective system in Massachusetts is based upon establishing a maximum allowable cost that will be paid to the hospitals in a given year. This reimbursable allowable cost fluctuates based upon adjustments for volume and inflation but provides to the hospital a predictable amount of income for the care of its patients. The system provides significant positive and negative incentives that will allow the hospitals to manage their use of patient care resources.

I will give an analogy to describe why a system still based on units of service is inappropriate: Think of a fire station. Imagine how improper it would be if we paid fire departments based upon the number of fires which they put out. Quite clearly, one can see that a perverse incentive would be created for the fire department in order to generate revenue. To effectively and efficiently operate, fire departments are given yearly budgets by their respective communities. With this yearly budget, incentives are appropriately placed and the fire departments have greater initiatives to work on fire prevention, consequently reducing the incidence of fires in the community with the resultant cost savings accruing to the community.

With respect to the "fire station" example, we believe it is appropriate to provide hospitals with a prospectively determined fixed budget that is independent of units of services. In this fashion, no longer will hospitals have to generate units of service in order to generate revenue. Rather, under the fixed budget approach, the incentives would quite clearly be to reduce cost, reduce unnecessary services, treat patients in more cost effective settings, etc.; and most importantly allow hospital management the delivery of health care services instead of managing the generation of revenue.

Second, Blue Cross of Massachusetts has made a significant commitment to the development of HMOs and the enrollment of Medicare beneficiaries in such. For example, at the Fallon Community Health Plan, a Blue Cross partnership HMO, we have enrolled 6,504 Medicare beneficiaries and have reduced the days per thousand from 4,400 to 1,910. Blue Cross of Massachusetts has concerns relative to HMO reimbursement under DRGs. In designing a Prospective Reimbursement System it is important to take advantage of existing vehicles for cost containment. A DRG based system applied to HMOs could undermine the cost savings inherent in the organization. The HMO financing and delivery mechanism provides incentives to control admissions, reduce lengths of stay and perform as many services on an ambulatory basis as is practically possible.

By reducing the overall demand for hospital services, HMOs should continue to be an integral component of strategies for removing excess hospital capacity from the system. It is our belief that we must assure that both the goals and the specific mechanisms of the prospective reimbursement system are compatible with HMOs.

Third, we suggest that any particular Reimbursement System (prospective or retrospective) will have opportunity for improvement. Such improvements are best discovered through experiments. We are therefore asking that the Secretary's power to conduct demonstration experiments be continued. This would allow all payor experiments such as in Massachusetts to proceed while HCFA is moving forward with its Medicare only system.

Fourth, a concern that is shared by all private sector insurance carriers is the potential for major cost shifting under this proposal. We are pleased to see that HCFA's proposal prohibits cost shifting back to the beneficiary. However, we are not convinced that the structure of HCFA's DRG system will prevent cost shifting to other payors. Two principles must be adhered to: (1) a fair and equitable rate of payment must be set and (2) the hospitals must operate within that level of reimbursement for Medicare beneficiaries.

Fifth, the legislative proposal to change Medicare should be sufficiently flexible to allow successful state or regional reimbursement programs to continue. We do not believe that it would be reasonable to discontinue our activities in Massachusetts and the other waiver states. Obviously, a state system different from HCFA's system should continue only if it is controlling the rate of increase in Medicare expenses in a fashion that is equal to or greater than what HCFA's Medicare only system is capable of delivering.

For example, the Fiscal Year 1984 Federal budget projects a national increase in Medicare hospital expenditures of 13.7 percent. The program in Massachusetts has guaranteed a rate of increase at least 1.5 percentage points less than the national average. The current projections for 1983 show savings in excess of that guarantee.

In summary, we applaud the effort to change the reimbursement mechanism from retrospective cost to a prospective system. However, Blue Cross of Massachusetts urges consideration of the five points made today.

Thank you.

Senator **Durenberger**. Thank you very much, both of you, for your testimony.

In an all-payor system I take it all people are not necessarily treated alike in terms of——

Mr. **Rogen**. I think it is fairly clear that the all-payor system is not a uniform system. For example, in Massachusetts we use the Blue Cross rate of payment as the basis for that system. Commercial insurance companies are paying 9 percent more, medicare is paying approximately 5 percent less, and medicaid, the State program, is paying some 15 percent less than the Blue Cross rate of payment. But it is a uniform system in terms of incentives as the hospitals are managing their program in the same way for all payors. But there are differences in the levels of payment.

Senator **Durenberger**. And where are the HMO's in those? Do they have their own rate?

Mr. **Rogen**. HMO's have two provisions. They have the right to negotiate their own contract outside of the system. But within the system they are allowed to apply for a discount if they can prove that it is warranted. The basic point on HMO's is that they are allowed to negotiate outside the system.

Senator **Durenberger**. Explain to me what you mean by the right to negotiate the right to that discount. What does that mean?

Mr. **Rogen**. They can, in essence, operate independently of that particular reimbursement system.

Senator **Durenberger**. But they have got a top limit they can negotiate down from?

Mr. **Rogen**. Well, the system certainly would not pay any more than charges. So you could say the top limit is charges, yes.

Senator **Durenberger**. All right. When you talked about Fallon—and we have heard about their success with the voucher program—you said be sure we make them compatible. Are there some specific recommendations that you have to insure that compatibility?

Mr. **Rogen**. What we would like to see is that when an HMO is effectively reducing the length of stay—and that is the objective of the DRG system—that it does have a leverage to either negotiate with the hospital for reduced cost of that case or is given outright benefit of the fact that it has reduced the length of stay in that particular case. There are a number of alternatives that we could make available to accomplish that.

Senator DURENBERGER. Are you managing an HMO or two up there?

Mr. ROGEN. In Massachusetts, Blue Cross is managing six HMO's with 135,000 members. Those HMO's are in all three models: Staff models, group models, and hospital-based operations.

Senator DURENBERGER. All in the same geographic area?

Mr. ROGEN. Throughout the State.

Senator DURENBERGER. And are they in competition with other HMO's in each of the areas they operate?

Mr. ROGEN. They are in competition with other HMO's, and I think we have a very competitive system developing in the Boston and Massachusetts area.

Senator DURENBERGER. I see.

Mr. TRESNOWSKI. Mr. Chairman, the point on all payors, the Massachusetts example is a waiver opportunity granted under the program. Our point on all payors is that the DRG system, if it is perfected as we have suggested, should not be applied to all payors across the country. We don't think that there is a single system that has been perfected that would be universally applicable. No. 2, we don't think that every community in this county is identical. There is great heterogeneity in our delivery system. There should be opportunity for various payors to negotiate based upon their business practices. That framework would offer the opportunity for a competitive environment.

An all-payor system legislated through the Congress and regulated through the Secretary, would be terribly intrusive into the process of private development.

Senator DURENBERGER. What problem would we see if we permitted the all-payor system on a State-by-State basis?

Mr. TRESNOWSKI. I think you would find, just as Dick has outlined in Massachusetts, that it works in Massachusetts. It works now in New York. A waiver has been granted to New York. And while New York has a different approach to payment, it is an all-payor system. I think every State should make its own decision on whether it should establish an all-payor system with different kinds of incentives. The negotiated differential of the Blue Cross plans might vary, depending upon the business practices of those plans. But the important thing is that every State should be allowed to evolve based upon its local circumstances and the characteristics of the actors in that environment.

Senator DURENBERGER. Is it possible for you to list a set of qualifiers before we would adopt any kind of a State-by-State waiver for an all-payor system. Are there certain things that you would want to see in a State system to make sure that the third party payors have some leverage on the system? If it would be possible to put that kind of list together in your experience, it would help.

Mr. TRESNOWSKI. I think so. I don't think that the Secretary would want to grant a medicare waiver there were some pretty specific criteria that would guide the manner in which that would operate. Obviously, you would have a lot of debate about what that criteria should be. For example, we would argue that imposing a DRG basis of payment as a condition of waiver, would in effect be using the waiver authority to impose a single payment on them, and we would obviously disagree with that. But there are constraints that we build in right now, and Dick could speak to this. There are guidelines that the Secretary uses in order to authorize a waiver, and basically they are sound. They require, for example, that the Government not pay more under the waivered payment system than they would under the other. And I think that is responsible and reasonable.

Mr. ROGEN. I would like to point to one of the interesting things that happened in the Massachusetts experiment. The Secretary basically looked to Massachusetts Blue Cross as its fiscal intermediary in that State and said, "you negotiate on our behalf the best deal that you can get with the hospital association." So they are looking to Blue Cross in that area to negotiate not only its own interests, but the administrations as well.

Senator DURENBERGER. On the general subject of negotiating, there are a lot of relatively small health insurers, and maybe some big health insurers, that are just small segments of a given market. What are your feelings about whether or not we should give legal permission to groups of health insurers to negotiate as a consortium?

Mr. TRESNOWSKI. The HIAA has recommended that they be given that authority under the legislation. That gets into a highly technical, legal argument I think and I don't want to get into that. I would simply answer the question by saying that the insurance companies, small or large, have the opportunity to negotiate right now. And as a matter of fact, a lot of them are doing it.

You have heard of the new concept—I say that amusingly because it is not so new in Blue Cross and Blue Shield—called Preferred Provider Organization, which is essentially a form of selective contracting. The AETNA Insurance Co. has now negotiated a contract with Evanston Hospital Lyola Medical Center in Chicago in which they have negotiated a price. And Dick was telling me that a similar program is being developed in Massachusetts with John Hancock Insurance Co. We have a very small insurance company in the State of Virginia that has negotiated contracts with a group of hospitals.

So I guess I would have to answer your question by asking, "why do insurers need some new authority if the opportunity is already there—if you want it, to strike out and take advantage of negotiated payment arrangements.

We also have a broad distribution of market share around the country, from a very high market share in States like Rhode Island and Massachusetts and New York, to the South and Southwest where we command low-market shares. And even in those areas where we have a low-market share we still contract. The size of the carrier isn't the primary consideration. I think it is a matter of its desire and willingness to sit down and go through the tough process of negotiation.

Senator DURENBERGER. I imagine Jack will answer that question.

Mr. TRESNOWSKI. I am sure he will. [Laughter.]

Senator DURENBERGER. You mention in your testimony that the hospitals may be penalized because they have special circumstances that the proposed payment method doesn't take into account. Could you just elaborate a little bit on what you would think would be some of the justifiable variations in these circumstances?

Mr. **Tresnowski**. All right. One of the fundamental things we don't know yet is what the impact of DRG's will be on various types of hospitals. As I said in my statement, under a national average scheme you are going to have winners and losers. The losers may be hurt badly and the winners may find themselves with substantial windfalls.

I think that this is a critical piece of information that the Congress ought to ask for soon, and I understand that the Department is working on it. In the absence of actual data we have done a small study. We established a national average bill rate for the country, and then we distributed around that average the average billing rate by State. We then adjusted that for the wage differential, as proposed by the administration. And even with the wage adjustment, the range in costs is five to one from hightest to lowest. The States with the high rates are all in the East and heavily populated Midwest, and the ones with the low rates are in the South and Southwest.

If we were to pursue that study further, and we haven't yet, we might find it to be true that very small hospitals will do very well under an average DRG.

Senator **Durenberger**. Are those the windfall winners you were talking about earlier?

Mr. **Tresnowski**. Yes. And it appears that the inner-city urban hospitals and the large teaching hospitals would do very poorly. Now if in fact that is what the missing data shows, that will raise a whole series of other questions about what kinds of incentives are built in to DRG's. For example, you have a capital pass through, which is a risky business under any circumstance, given the capital intensity and some of the other problems you have with capital investment in the health industry. But if a hospital experiences a windfall, say 25 percent above the average, and also has a pass through on capital, it provides a wonderful opportunity for that hospital to enlarge the scope of its services perhaps beyond what they should be.

It is the kinds of incentives that flow from a DRG system that we think should be looked at carefully. I say that, Mr. Chairman, against the background that we think the present medicare program payment system should be changed. We think it lacks incentives and that the DRG approach is not, inherently, a bad approach. It just needs more evaluation, analysis and experience before we make such a tremendous change as contemplated on October 1 of this year.

Senator **Durenberger**. I think it is getting a very thorough, and very thoughtful analysis from everybody who has been testifying on this subject. A lot of people have gone through a lot of work to point out the strengths and weaknesses of this system. Today's hearing has been very, very helpful.

Is there anything each of you want to add?

Mr. **Tresnowski**. No, sir. Thank you.

Mr. **Rogen**. No, sir. Thank you.

Senator **Durenberger**. All right. Thank you very much for your testimony.

The next witness will be Mr. John K. Kittredge, executive vice president, Prudential Insurance Company of America, on behalf of the Health Insurance Association of America. Welcome, Jack.

STATEMENT OF JOHN K. KITTREDGE, EXECUTIVE VICE PRESIDENT, PRUDENTIAL INSURANCE COMPANY OF AMERICA, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. KITTREDGE. Thank you, Mr. Chairman. We appreciate the opportunity to add our industry's views to this discussion both on the general issue of how hospitals should be paid and on the recently announced Department of Health and Human Services' proposal, in particular.

The Department has produced a proposal which serves as a good starting point for discussion of the issues. The administration proposal would change the present retrospective determination of payments to hospitals to a prospective method of pricing. We believe that this conceptual change is highly desirable. But any system that does not apply to all patients will not create the desired change in hospital incentives.

We believe that any prospective pricing system enacted by Congress, should apply to all patients and all payors, and not just medicare, and not require a single Federal approach to prospective pricing, but instead encourage States to develop their own programs that would cover all patients in the State.

The change in medicare payment would probably not have been proposed were it not for the very rapid increases in health care costs in recent years. These increases which have continued at an alarming rate are even more applicable to the insurance coverage purchased by employers for their employees and by individuals for themselves. Even though there has been a decline in the overall rate of inflation, health insurance premiums are increasing at annual rates which average over 20 percent, but may be much higher for any employer or individual. These increases adversely affect the health of American industry and ultimately are shared by employees and consumers. A prospective pricing system which applies only to medicare will hold down medicare costs, but will clearly shift additional significant costs to other payors. In fact, I think it would be wise to point out that this is different from the kinds of cost shifts that have taken place up until now. Up until now the cost shifts have resulted from a reduction in cost to the Government programs. In this instance, there will be costs that are shifted to other payors which are not offset by corresponding reductions in cost to the Government.

Further, if the change to a prospective system provides the right incentives to health care providers to control health care expenses—and we agree that it does—such a change is equally needed for the coverage of those who are not under medicare. We believe that prospectively determined hospital prices can begin to introduce supply and demand forces in the health care market, but cost containment cannot be achieved unless all patients, regardless of coverage, are included in the same pricing system. This does not necessarily mean that all patients pay identical prices, but they should certainly pay prices which differ only on an equitable basis.

We believe that the most appropriate way to accomplish this goal is at the State level because Pennsylvania is not Minnesota, and Minnesota is not New Jersey. The Federal Government currently participates in several State programs in prospective pricing. Of these, Maryland and New Jersey have been operating under HCFA waivers that allow medicare and medicaid rates to be set on the same basis as other patients' rates.

The results have been positive. In 1981, Maryland produced medicare and medicaid savings of $37.3 million. In Maryland, 1981 hospital revenues increased 14.5 percent while New Jersey hospital revenues increased 14 percent, versus 18 percent nationally.

We argue against requiring a uniform, federally administered system. We also believe that State-based programs covering all patients can be consistent with the goals of increasing price competition among providers—if comparative price information is publicized.

This is a developing area and no one yet has all the answers to the questions of hospital payment reform. The Maryland and New Jersey systems, which have both been effective, operate quite differently. Federal legislation should be the catalyst that encourages variety and innovation. HHS recently granted medicare waivers to New York and Massachusetts, two of the Nation's high cost States. We believe these different approaches will lower costs and produce useful comparisons. We urge that any legislation you adopt provide incentives to States to develop their own programs, covering all patients, including medicare and medicaid.

I would like now to turn to the Diagnostic Related Groups, or DRG, system. The Department's proposal involves a form of DRG. Prudential has closely followed the development of the DRG-based program of New Jersey, our home State. Properly utilized, DRGs have the potential to change physician behavior, a key to containing hospital costs.

Several New Jersey hospitals are effectively using DRG data to discuss excess lengths of stay and other changes in illness treatment with attending physicians. At West Jersey Hospital, for example, this has led to a change from an average length of stay in 1979 of more than 10 days to an average of less than 7 days in 1982. By including all patients, Government and private, the program protects hospital solvency, avoids cost shifting, and encourages private sector competition.

There are several features about the administration's proposal which concern us, based upon our understanding of the material which we have seen. One, we believe it is unrealistic for the system to be applicable on October 1 for all of the hospitals to which it is to apply in the United States.

New Jersey phased their DRG program in over a 3-year period. Even though the New Jersey hospitals have been subject to a State mandated prospective budgeting process prior to the original introduction of DRGs, the shift was no without difficulty.

Two, we are concerned that the administration's proposal attempts to apply the same DRG values to all short-term acute care hospitals in a geographic area. For a number of reasons, the actual cost of treatment by DRG will vary from hospital to hospital within a geographical area.

New Jersey addressed this problem by establishing its initial DRGs based on a blend of regional experience and the experience of each individual hospital. In this way, undue windfalls for some hospitals were avoided and those hospitals with higher costs were provided time to make an adjustment the new system.

Three, the New Jersey approach also calls for payments for those confinements which are beyond upper and lower limits of stay to be based upon controlled charges. The administration's approach is likely to have produced unintended and possibly very adverse effect upon smaller hospitals through no fault of their own.

Four, we are concerned that the proposal appears to include no audit process.

Five, we believe a formal appeal process should be included for hospitals which encounter unusual hardships under the program.

Six, we anticipate that the proposal, if adopted, would create hardships for many teaching and inner-city hospitals. These hospitals, for legitimate reasons, generally have higher expense levels than other hospitals. The provision for passthrough of medical education costs is not sufficient to adjust for the differences.

It is not clear to us how the DRG payments will be adjusted in the future to take into account price inflation changing intensity of care, and development of new methods of treatment. It is important that this be spelled out carefully.

In summary, we support a change to a system of payment for hospitals with prospectively determined prices which are not a function of the specific services used. We support such a system only if it applies to all patients and all payors. We believe that the Nation will be best served if any legislation includes incentives to encourage development of consistent programs at the State level where the programs can be tailored to meet local economic and health care needs

Thank you.

[The prepared statement of Mr. Kittredge follows:]

STATEMENT
# of the
HEALTH INSURANCE ASSOCIATION OF AMERICA

Presented by
John K. Kittredge

My name is John Kittredge. I am an Executive Vice President of The Prudential Insurance Company of America. I am appearing today on behalf of the Health Insurance Association of America, a trade association with 338 member insurance companies. Insurance companies provide hospital expense coverage for over 100 million Americans.

We are pleased that you have decided to raise the issue of the basis on which hospitals should be paid early in the 98th Congress. This important and complex issue requires significant debate. We appreciate the opportunity to add our industry's views, both on the general issue of how hospitals should be paid and on the recently announced Department of Health and Human Services proposal in particular. The Department has produced a proposal which serves as a good starting point for discussion of the issues.

The Administration proposal is to change from the present retrospective determination of payments to hospitals to a prospective method of pricing. We agree that this change in concept is highly desirable. But, any system that does not apply to all patients will not create the desired change in hospital incentives.

We believe that any prospective payment systems enacted by the Congress should:

- apply to all patients and all payors and not just Medicare, and

- not require a single federal approach to prospective pricing, but instead encourage states to develop their own programs that would cover all patients in the state.

The change in payment basis under Medicare would probably not have been proposed were it not for the very rapid increases in health care costs in recent years. Those increases which have continued at an alarming rate are even more applicable to the insurance coverage purchased by employers for their employees and by individuals for themselves. Even though there has been a decline in the overall rate of inflation, health insurance premiums are increasing at annual rates which average over 20%, but may be much higher for any employer or individual. These increases adversely affect the health of American industry and ultimately are shared by employees and consumers. A prospective pricing system which applies only to Medicare will hold down Medicare costs, but it will clearly shift significant additional costs to other payers. Further, if the change to a prospective system provides the right incentives to health care providers to control health care expenses, and we agree that it does, such a change is equally needed for the coverage of those who are not under Medicare.

Those of us who are in the health insurance industry know the shortcomings of the current reimbursement system, which offers a blank check to hospitals. The current system encourages hospitals to spend money in order to get more. If a system reimburses hospitals for daily charges, a hospital administrator may cover fixed costs by encouraging weekend admissions for Monday surgeries. If every laboratory test generates a separate reimbursement, a hospital administrator can encourage use of ancillary services by bringing in new and more costly equipment.

The participants in the health care marketplace agree that incentives in the hospital industry are misplaced. In recognition of this, the major hospital trade associations are on record in support of system reform based on prospectively-determined prices.

Prospectively-determined hospital prices can begin to introduce supply and demand forces in the health care market. We concur with HCFA's stated goals for its program--hospitals should be able to project their bottom lines, and should be at risk, that is, able to retain any surplus generated by increased efficiency. These concepts are basic to most industries, including the insurance industry. Accordingly, the goals make sense not only for Medicare, but for all patients. A fragmented system will not achieve the change in basic incentives that DHHS seeks. A Medicare-only system may save money in the federal budget in the short run, but the long-term increase in aggregate health costs will continue.

The cost shift has been well documented since our industry publicly identified the problem a couple of years ago. Until recently the phrase "cost-shift" referred only to those business expenses incurred by all hospitals, which were excluded from the calculation of Medicare payments such as bad debts, charity care and research. But in the last few years a new form of cost-shifting has appeared as Medicare and Medicaid have reduced their payments by artifically limiting reimbursable costs. As a logical business practice, hospitals make up losses from highly restricted Medicare and Medicaid reimbursements by increasing charges to private patients. These include the patients insured by our member companies, with premiums paid by our clients. Cost containment cannot be achieved unless all patients, regardless of coverage, are included in the same pricing system. This does not necessarily mean that all patients pay identical prices, but that they certainly should pay prices which differ only on an equitable basis.

We believe the most appropriate way to accomplish this goal is at the state level because Pennsylvania is not Minnesota, and Minnesota is not New Jersey. The federal government currently participates in several state programs in prospective pricing. Of these, Maryland and New Jersey have been operating under HCFA waivers that allow Medicare and Medicaid rates to be set on the same basis as other patients' rates.

The results have been positive. In 1981, Maryland produced Medicare and Medicaid savings of $37.3 million. In Maryland, 1981 hospital revenues increased 14.5%, while New Jersey hospital revenues increased 14.0%, versus 18% nationally. But the data does not tell the complete story about prospective pricing. The state systems are too new and varied. We regard this variety as a major asset that state systems offer. We argue against requiring a uniform, federally-administered system. We also believe that state-based programs covering all patients can be consistent with the goals of increasing price competition among providers--if comparative price information is publicized.

This is a developing area and no one yet has all the answers to the questions of hospital payment reform. The Maryland and New Jersey systems, which have both been effective, operate quite differently. Federal legislation should be the catalyst that encourages variety and innovation. HHS recently granted Medicare waivers to New York and Massachusetts, two of the nation's high cost states. In both of these states, all parties with a direct stake in hospital payment change--providers, employers, unions and insurers--actively participated in designing a solution. Both are implementing approaches different from those in Maryland and New Jersey. We believe these different approaches will lower costs and produce useful comparisons. The Federal Government's role as a catalyst has helped formulate these two programs. We believe this is a prime role for the Federal Government and should be continued. We urge that any legislation you adopt provide incentives to states to develop their own programs, covering all patients, including Medicare and Medicaid.

I would like to turn now to the Diagnostic Related Groups, or DRG, system. The Department of Health and Human Services proposal involves a form of DRG. Prudential has closely followed the development of the DRG-based program of New Jersey, our home state. As with any new and complicated change, this system has had some problems, but they are primarily technical and we are confident they will be worked out. Based on our observation of DRGs as used in New Jersey, we are convinced that they offer a significant management tool to hospitals, while creating appropriate cost containment incentives. Properly utilized, DRGs have the potential to change physician behavior--a key to containing health costs. Several New Jersey hospitals are using DRG data to inform attending physicians of excess lengths of stay. For example, Morristown Memorial and West Jersey Hospitals use printouts for each physician, listing the costs of each treatment item and patient length of stay. The listings allow for comparisons of physician practice patterns: if a physician is out of step with other doctors, the physicians' DRG committee negotiates with the doctor. Both hospitals have found that when a doctor learns that his colleagues' patients have similar recoveries with shorter stays, the doctor begins to discharge patients sooner. At West Jersey, this has meant a change from an average length of stay in 1979 of more than ten days to an average of less than seven days in 1982. The New Jersey system creates incentives to reduce tests and weekend admissions, and to reduce lengths of stay, but does not create an incentive for hospitals to avoid complex cases. All of this has been accomplished without compromising quality of care. By including all patients--government and private--the program protects hospital solvency, avoids cost shifting, and encourages private sector competition.

I would like to turn now to the Administration proposal and make some specific comments with respect to it. Some positive features with which we agree are:

1. It uses a system which is based upon each hospital's actual current case mix, rather than the case mix at some time in the past. This assures a reasonable matching between the payments and the kinds of care being provided. In addition, it minimizes the risk of hospitals deliberately changing their case mix in order to "beat the system."

2. Under the proposal hospitals are at risk. We believe that it is generally appropriate that hospitals be permitted to keep any gains arising from the system as well as being required to bear any losses produced by it.

3. We believe the adjustment for local wage rates is appropriate.

There are several features about the proposal which concern us based upon our understanding of the material which we have seen:

1. We believe that it is unrealistic for the system to be applicable on October 1 for all of the hospitals to which it is to apply in the United States. New Jersey phased their DRG program in over a three-year period. Even though the New Jersey hospitals had been subject to a state-mandated

prospective budgeting process prior to the original introduction of DRGs, the shift wasn't without difficulty. It undoubtedly would have been much more chaotic if the State had attempted to apply it to all hospitals at one time.

2. We are concerned that the Administration proposal attempts to apply the same DRG values to all short-term acute care hospitals in a geographical area. For a number of reasons, the actual costs of treatment by DRG will vary from hospital to hospital within a geographical area. Some hospitals, admittedly including the more cost-effective ones, will be in a position to profit significantly while others will have great difficulty bringing their expenses down to the levels generated by the DRG payments. We doubt that those hospitals making significant profits will use their gains to reduce the charges for other payers. On the other hand, the hospitals with considerable Medicare shortfalls will undoubtedly attempt to make up the difference from other payers.

   New Jersey addressed this problem by establishing its initial DRGs based on a blend of regional experience and the experience of each individual hospital. In this way, undue windfalls to some hospitals were avoided and those hospitals with higher costs were provided time to make an adjustment to the new system. The expectation is that the regional values will receive increasingly higher weighting in the DRG calculation.

3. The proposal does not include another important feature applicable in New Jersey. The New Jersey approach calls for payments for those confinements which are beyond upper and lower limits of stay to be based upon controlled charges. The Administration approach if applicable only to Medicare might work out reasonably well for larger hospitals. However, it is likely to produce unintended and possibly very adverse effects upon smaller hospitals through no fault of their own. In 1982, an estimated 30-35% of the cases fell outside the New Jersey guideline confinement tests.

4. We are concerned that the proposal appears to include no audit process. We believe it important that there be a review of each hospital's activities to assure that confinements are appropriately classified and that the process is followed correctly.

5. The proposal appears to include no formal appeal process for those hospitals for whom the program creates unusual hardships. We believe such an appeal process should be included.

6. We anticipate that the proposal, if adopted, would create hardships for many teaching and inner-city hospitals. These hospitals, for legitimate reasons, generally have higher expense levels than other hospitals. The provision for pass-through of medical education costs is not sufficient to adjust for the differences.

It is not clear to us how the DRG payments will be adjusted in the future to take into account price inflation, changing intensity of care, and development of new methods of treatment. It is difficult to comment upon the appropriateness of the proposal as it will apply in the future without specifics in this area.

In summary, we support the change to a system of payment for hospitals with prospectively determined prices which are not a function of the specific services used. We support such a system only if it applies to all patients and all payers. We believe that the nation will be best served if any legislation contains incentives to encourage development of consistent programs at the state level, where the programs can be tailored to meet local economic and health care needs.

Therefore, Mr. Chairman, we specifically request and recommend:

1. for the prospective payment system to apply to all patients and all payors and not just Medicare, and not require a single federal approach to prospective pricing, but instead encourage states to develop their own programs that would cover all patients in the state;
2. that the state option for Medicare payment enacted last year be strengthened and clarified; and
3. that insurers be specifically authorized to engage in joint health care cost containment activities, such as sharing data, negotiating with health providers, and developing computerized profiles on patterns of care.

Senator DURENBERGER. Thank you very much. Let me ask you a couple of questions, first, that come from other members of the subcommittee. We have been kicking around during the course of the day the possibility of State waivers for all payor systems. Can you respond to the same kind of question that I asked Blue Cross relative to what kind of criteria should we establish for those waivers?

Mr. KITTREDGE. We would be pleased. I don't have a set with me at this point, but we would be pleased to supplement my statement a suggested set.

Senator DURENBERGER. All right. I appreciate that.

[The suggested set follows:]

HEALTH INSURANCE ASSOCIATION OF AMERICA
CHICAGO • NEW YORK • WASHINGTON

February 17, 1983

The Honorable David Durenberger
Chairman
Subcommittee on Health
Committee on Finance
2227 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Mr. Chairman:

I greatly appreciated the opportunity to present the views of the Health Insurance Association of America at your Subcommittee's hearing today. It was particularly pleasing to be given the opportunity to reply to your searching questions. Hopefully, my replies will add to the understanding of the problems.

You asked me if we had suggested criteria for State options which might apply in conjunction with a prospective payment system for Medicare. Attached to this letter, for the record, is suggested wording which is an adaptation of the similar language which was included in TEFRA.

This wording differs from that in TEFRA in two respects:

1) in the first line the word "may" has been changed to "shall", and

2) paragraph (4) has been added.

The reason for these two changes is to clarify an intent that States will be permitted to adopt systems which meet the criteria setforth in the proposed section without also having to meet possibly onerous additional requirements imposed by the Secretary. We believe that it is important, as my testimony explained, that States be encouraged to adopt differing systems with the expectation that we can learn from those systems how to improve prospective payment plans generally.

Sincerely,

John K. Kittredge
Executive Vice President
Prudential Insurance Company
of America

Attachment

STATE OPTION FOR MEDICARE PAYMENT

Title XVIII of the Social Security Act as amended by revising Section 1886(c) to read as follows:

"(c)(1) The Secretary shall make payment with respect to services provided by a hospital in a State in accordance with a hospital reimbursement control system in a State, rather than in accordance with the other provisions of this title, if the chief executive officer of the State requests such treatment and if—

"(A) the Secretary determines that the system will apply (i) to substantially all nonfederal acute care hospitals (as defined by the Secretary) in the State and (ii) to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and of revenues or expenses for inpatient hospital services provided under the State's plan approved under title XIX;

"(B) the Secretary has been provided satisfactory assurances as the equitable treatment under the system of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients; and

"(C) the Secretary has been provided satisfactory assurances that under the system, over 36-month periods (the first such period beginning with the first month in which this subsection applies to that system in the State), the amount of payments made under this title under such system will not exceed the amount of payments which would otherwise have been made under this title not using such system.

"(2) In determining under paragraph (1)(C) the amount of payment which would otherside have been made under this title for a State, the Secretary shall provide for appropriate adjustment of such amount to take into account previous reductions effected in the amount of payments made under this title in the State due to the operation of the hospital reimbursement control system in the State if the system has resulted in an aggregate rate of increase in operating costs of inpatient hospital services (as defined in subsection (a)(4)) under this title for hospitals in the State which is less than the aggregate rate of increase in such costs under this title for hospitals in the United States.

"(3) The Secretary shall discontinue payments under a system described in paragraph (1) if the Secretary—

"(A) determines that the system no longer meets the requirement of paragraph (1)(A) or

"(B) has reason to believe that the assurances described in subparagraph (B) or (C) of paragraph (1) are not being (or will not be) met."

"(4) In determining whether or not to make payments to hospitals in a State in accordance with that State's hospital reimbursement control system, the Secretary shall consider only the requirements specified in paragraph (1) and shall impose no other conditions or requirements."

Senator DURENBERGER. When you talked about all payors, I thought you also said all patients.

Mr. KITTREDGE. All patients.

Senator DURENBERGER. Does that mean, in effect, that each payor uses the same DRG and the entire DRG system applies to all patients, young and old?

Mr. KITTREDGE. No. Fairly clearly, that would be inappropriate. I would expect that many of the DRGs that would be appropriate for the nonmedicare population would be lower than the medicare DRG since the medicare population is obviously older, and for many conditions involves individuals who require much greater intensity of care and perhaps more care. What we do believe is important is that there be equity among payors, not a uniform DRG system.

Senator DURENBERGER. So age is clearly one of the criteria that would set the medicare DRG aside from others. Are there others?

Mr. KITTREDGE. Yes. In fact, if you look at the New Jersey DRG, there are a number of DRGs which do differentiate by age.

Senator DURENBERGER. Are there other criteria? Someone this morning talked about sex as a criteria. Might that be an appropriate criterion for a specific diagnostic rate of grouping?

Mr. KITTREDGE. I would say at this point I question that we know enough to make that kind of differentiation. The DRG program in New Jersey we think has worked effectively. We think it is an excellent start. But I would be the first one to say that I don't think anyone is close to having all of the final answers. And this is one of the reasons why we urge a program that permits variations by state in the hopes that through the application of different kinds of system we will gradually improve the technology of applying prospective payment systems that is likely to emerge.

Senator DURENBERGER. The Group Health Association testified this morning that they are very concerned about all-payor systems because they eliminate the negotiating flexibility they need to keep costs down. They would like to be able to negotiate rates based on legitimate advantages that they bring to the hospital. Prudential has what? 8 HMO's that you either own or manage?

Mr. KITTREDGE. We only manage about 10 at this point.

Senator DURENBERGER. Ten of them. Would you explain to us your feelings with your Prudential hat on rather than your HIAA hat on about the testimony that they gave us?

Mr. KITTREDGE. Well, first of all, I did not read or I hear the GHAA testimony. I do think that there is one area that needs some clarification perhaps before I try to answer your question, because I have read testimony dealing with the New Jersey experience of HMO's that has been given previously. And I think it is important to recognize that two things happened concurrently in New Jersey. The first is that legislation was passed which created a prospective payment system with equitable relationships to be established as to the relative amounts paid by all payors. Prior to that time the prospective payment system, or prospective budgeting system, had applied to payors other than private insurers and uninsured individuals. At the same time a prospective payment system was developed which used DRG's. Either one could have happened independently of the other. And I have the feeling that there may be some confusion in interpreting the numbers as to which of these changes was responsible for what.

The net effect of the first change was to reduce by a fairly considerable margin the differential which had existed between Blue Cross and commercial insurers in terms of the payments that are made. There is still a differential, but it is a much lesser differential than it had been previously. And a very similar thing happened with respect to HMO's, including the one individual practice association in New Jersey which Prudential manages. So I would not blame DRG's for the sole difference in terms of the effect on HMO's.

I do not know the answer to the question as to what is the precisely best way in which to treat HMO's under a DRG system. I would point out though that the lower number of days per population of hospital confinement in DRG's comes roughly from two different sources. One is through confinements that never take place but would have under more traditionally insured coverage. And in those instances, the existence of a DRG system makes no difference at all. They still would have no payment.

The second is differences in terms of lengths of confinement, amount of treatment, and so forth, among those HMO patients who are in fact hospitalized. And with respect to some conditions, such as normal delivery, fairly clearly HMO's in many parts of the country do end up with lower costs. But what I don't know is the degree to which this may be offset by greater complications among some of the other confinements because the less seriously ill never got confined in the first place.

To answer your question, I think that the right answer is some form of equity in terms of adjustments of different levels of DRG payments as between HMO's and other than HMO's. But I personally do not know enough, and I am not sure that anyone as yet has really done the research to determine what the right answers are.

Senator DURENBERGER. All right. One last question. What are the laws, the regulations, or other mechanisms that restrain your ability in the health insurance industry to negotiate prices with hospitals?

Mr. KITTREDGE. Well, it is basically our concern with antitrust laws and possible application of antitrust laws at both the Federal and the corresponding laws at the State level. I heard Mr. Tresnowski testify a few minutes ago that there is nothing that he can do that cannot be done by private insurers, and he gave two or three examples. I think I would like to comment and elaborate on my viewpoint with respect to that.

Senator DURENBERGER. Please do.

Mr. KITTREDGE. Prudential is the largest commercial health insurer in the country, and we cover a grand total of 4 percent of the total market. That is not a very dominant part of the market. There are States in geographic locations where we have a higher percentage, and there are others, such as Rhode Island, where we have a much lower percentage.

I would suggest, however, that the percentage that we have in any one State is such that we don't have anything like the economic power that the Blue Cross organization has in most of the States in which they operate. But it is not only a question of what is the bargaining power that the organization has, but the history from which one starts. The Blue Cross organizations would be starting from a history of having long standing contracts, many of which have applied back for, oh perhaps 40 years or even longer, and which are much more difficult for the hospitals to change from in response to any bargaining results or concessions that they might make to a commercial insurer.

I would also point out that Mr. Tresnowski used the example of an Aetna negotiation with what is becoming known as a preferred provider organization. It has been our observation that those providers who are interested in forming preferred provider organizations very frequently fall into one or two categories. Either they are in locations where they are acting in defense against the competition which is coming at them from an HMO, or more than one HMO's. And in at least one instance, the Evanston Hospital in Evanston, Ill., we happened to run the competing HMO, and I suspect I would be surprised if there wasn't a certain reaction, a defensive reaction, in making the providers more willing to bargain there.

The second instance is where there is a surplus supply of providers, and the providers are looking for means of trying to increase their flow of patients and income. That doesn't mean that preferred provider organizations won't be formed in other locations and that similar mechanisms won't be developed, but those are certainly the instances where it is applied most frequently.

We have attempted in the past to negotiate individually with hospitals to try to get a reduction on the basis of prompt payment, on the basis that our benefit plans in the area provide full payment or very close to full payment. And although we have had very limited success in a few instances, and in most instances we get told to get lost.

Senator Durenberger. What is the typical State antitrust problem?

Mr. Kittredge. The States have antitrust laws which are in many instances somewhat similar to the Federal law. I am not an antitrust lawyer or an antitrust expert, but this is what our lawyers tell us. Even if we did not have to be concerned with the Federal antitrust laws, that in terms of joint negotiations with working with other carriers that we would similarly have questions in many States.

Senator Durenberger. But in effect it is anti the discounting process, isn't it, in terms of the hospitals' ability to negotiate with one provider a rate that differs from the negotiated price with another insurer?

Mr. Kittredge. I guess I would suggest that the negotiation process is fine if both sides in the negotiation has some reasonable number of chips. And I think in this instance we generally do not. And I am sure you are aware that the health insurance industry has been urging that Congress consider legislation which would give us some very limited powers to negotiate on a joint basis.

Senator Durenberger. Senator Long, do you have any questions?

Senator Long. No questions.

Senator Durenberger. All right. I thank you very much for your testimony and your response to the questions.

Mr. Kittredge. Thank you.

Senator DURENBERGER. The next witness is Willis Goldbeck, president of the Washington Business Group on Health. We welcome your participation in this ever more intriguing process.

STATEMENT OF WILLIS GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, D.C.

Mr. GOLDBECK. Thank you, Mr. Chairman. I am Willis Goldbeck of the Washington Business Group on Health. I will make a few points to summarize our general statement which you have already received.

I think at the outset it is essential to recognize that every economic and medical care utilization trend that brought you to the table to begin consideration of this issue is going to be considerably worse in 1983. The problems are not being addressed now; therefore, moving into a system's restructuring effort seems to really be the only choice that is left. Tinkering has proved uniquely ineffective.

Our organization appears today in support of the prospective pricing DRG proposal. We do that fully recognizing that it is not the solution to all the cost problems. Therefore, I might add it also shouldn't be criticized for failing to solve all the cost problems. It isn't designed to do that.

We also believe that the cost shifting issue is not an adequate reason to oppose this proposal, even though we clearly are the principal cost shiftee at least in many people's estimation of what is likely to happen. I couldn't help but find it somewhat interesting to hear Massachusetts described as the model of competition. It is also the model of the most outrageously high priced medical costs in the United States. So if that is indeed the model of competition then the advocates of competition have more to worry about than even I thought.

We feel very strongly that the proposal must have a utilization review component included in it; that that not be conducted by the fiscal intermediaries; and, therefore, quite reasonably the Senate should lead the way in funding the PRO program which emanated from you and from this committee.

When we say utilization review we mean pre admission, current, and appropriate retrospective analysis. Separately, none are sufficient. We endorse the concept of State waivers, feeling that there needs to be flexibility. And indeed if there had not been such flexibility a few years ago, the DRG proposal itself would never have been tested at all.

We believe that the proposal, when passed into law, should include capital costs and physician fees within the DRG pricing system. We fully understand, as presented by the administration, corroborated in the Ways and Means hearings the other day, that there is a problem with the data base to enable one right now to include either capital costs or physician fees. Fully respecting that, it seems then the Congress should include those as requirements now with the phase in schedule respective of what actually will be needed to develop the data. Without making it a requirement, I think we are all realistic enough to know that the process of the data development would take considerably longer.

Education should remain outside the DRG regardless of the capacity, in terms of data systems, to put it inside. The country needs to come to grips with how much medical education it needs and how it should be paid for. It shouldn't be paid for only out of the pricing for the individual patients who happen to go into a given institution at a given point in time.

We believe there should be no provisions that would allow any institution or individual physician provider to bill medicare patients above the legislated cost-sharing requirements. Increasingly, all of these changes suggest that medicare assignment should be a requirement, not an option. We do not support the idea that there should be a hospital-by-hospital difference in the DRG pricing.

Future adjustments can be made to the DRG if it turns out that that is a significant problem. It strikes me that the concern that the DRG's on an areawide basis might not fit every hospital's need is tantamount to saying we ought to have every hospital survive. Part of the purpose of going through a significant restructuring is to change the status quo. We are all in agreement that there is indeed significant excess utilization of the system today and the bulk of that resides in inpatient care in hospitals.

We believe it would be useful to attach a requirement that the use of the uniform billing, UB-82, be accelerated to coincide with the actual implementation schedule of the prospective pricing DRG program.

I recognize that a lot of people have expressed concerns about two class systems of medical care in the United States and whether or not the DRG's would contribute to that onerous circumstance. It is important to recognize that the DRG's will neither solve or greatly exacerbate what we already have, which is in fact the two class system of medical care. I don't find any wealthy people volunteering to be treated as medicaid patients in the United States, and I don't think we ever will, and there is very good reason for it. So what we can see with the development of the DRG system is that you do have a possibility of developing price and quality specific, comparative information, so that all purchasers and all categories of patients and their representatives will be in a position to compare physicians and hospitals. That is one of the major developments of this piece of legislation that would contribute to reducing two classes of medical care in the United States. At least you would know what you are buying.

We raise the caution that some others have as well about the problem of using historical costs as the basis of the DRG pricing development. The largest missing piece in terms of an information base for the health care delivery system in the United States today is the absence of any outcomes validated standards or norms based on current practice capability as opposed to current practice patterns which tend to reflect what people learned 15 years ago.

Perhaps the greatest potential of this DRG system is the ability to change practice patterns. DRG based reimbursement provides an incentive to change those practice patterns. We think that the suggestions Senator Baucus has made for an advisory commission for the explicit purpose of coming out with some validated standards would be a very valuable asset to this entire program.

We are certainly concerned about cost shifting. Part of the onus now is on us to fight that problem, hopefully with integrity, in the various States and communities around the country where we as employers have significant numbers of covered persons. It is naive to think that individual businesses can totally resolve the issue because they, not unlike Mr. Kittredge's very accurate comments about the insurance industry, in most places aren't unlike small businesses. They don't employ very many people, and they certainly don't control very much of the patient load of major hospitals. There will be more and more collective kinds of purchasing arrangements which we think is a very positive step, again with the objective of changing practice patterns.

I would note that we do not accept the idea that a preferred provider organization that simply negotiates discounts means anything. In fact, that is nothing more than another form of cost shifting among private payors. If there are two companies in the same town, and one negotiates a slightly better rate with a hospital than another, obviously the hospital can cost shift on to the patients of that other private sector payor just as they could if the reduction had come from a public sector revenue source.

The PPO's, that are worthwhile and want to be considered in the same way that HMO's are considered in this program are those which marry the negotiated discounting process with a utilization control component, so that patients are guided to those providers who in fact are designated as being preferred. It doesn't do me as a major employer any good at all to negotiate a 5 percent discount with a hospital and let the employees go anywhere they want for care. The idea is to correct the discount on pricing with utilization controls and comparative information that enable people to understand the quality differences as well as the pricing differences among providers of all types.

We believe that even though we are accepting the concept that one does not have to begin a system such as this on an all payor basis, that there ought to be a full disclosure requirement for all payors. All providers and all carriers, as intermediaries be required to make price and utilization information available to all who want it, period. There ought to be no more of this issue of whether or not one is allowed to get data from a hospital. How long must it take to negotiate the privilege of receiving data about the utilization that you have already paid for? If we want to have the public sector developing its programs and the private sector developing its own in hopefully some coordinated fashion, it is essential there is full disclosure of information so all of us in the United States can know what we are buying from whom based on a reasonable set of standards.

Let me close by stating that this is exactly the right legislative direction. It is consistent with what the major purchasers in the private sector are doing. It also is a very strong challenge to the providers. It seems that this could very well be the last chance for the hospital industry and for the physicians and others in the provider community to find the employers strongly on the side of diversity. If the only reaction is massive cost shifting, because that seems to be the short-term expedient way to beat the system, then the employers will be left with little choice but to begin more strongly to move in support of governmental controls. Thank you very much.

[The prepared statement of Willis B. Goldbeck follows:]

Washington Business Group on Health

Prospective Pricing

Testimony Presented To

The Health Subcommittee of the Senate Finance Committee

Willis B. Goldbeck
President
Washington Business Group on Health
February 17, 1983

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My name is Willis B. Goldbeck, President of the Washington Business Group on Health. We appear before you today with concern about the future of our Nation's medical care delivery system. The companies which belong to our Group do so becuase they, as very large employers, have awakened to the need to become active purchasers of medical care services, no longer remaining passive payers of insurance.

Changing from the current "cost-plus" system of paying for Medicare to a prospective pricing system is long overdue and laudable. As the nations' largest single purchaser, Medicare can, with this new system, set the standard against which the cost management efforts of all other purchasers may be measured. In fact, the proposed system, goes way beyond any of the historical tinkering that previous Administrations and Congresses have attempted. More than just a cost saving regulation, the proposed system represents a philisophical shift: for the first time the purchaser will have utilization and cost management tools and the provider will have the economic incentive to perform in a cost-efficient style. To move from payer to manager is a progression that we view as entirely consistent with steps being taken by the leaders in the private business sector. Just consider these changes, all of which have taken place within the past five years:

1. *from serving on planning boards to starting planning systems*

2. *from questioning the value of utilization review to contracting with PSRO's to forming mutiple employer reviews systems*

3. *from refusing to endorse state rate setting to starting just such a program in Massachusetts. In 1983, employers will be pressing for similar pricing systems in Illinois and Pennsylvania, to name just two others.*

4. *from little awareness of the role of the FTC to a defense of the FTC against the efforts of orgainized medicine to obtain a broad exemption. Employers have learned at least one lesson these past few years: Medicine is clearly a business!*

5. *from reliance upon the concept of indemnity insurance to an almost total revision of that concept in favor of varied capitation, cafeteria, multiple choice, high-low option, preferred provider,* and in-house care delivery programs.

6. *from curiosity about prevention to general acceptance of wellness and employee assistance programs as the fastest growing employee health benefit.*

7. *from well-intended but naive reliance upon singular cost control approaches to recognition of the need for cost management strategies that integrate utilization, reimbursement, and capacity-controlling efforts.*

8. *from single-company efforts to the coalition movement which can now be found in nearly 100 communities and has the active participation of over 1000 employers.*

9. *from acquiescence to providers to outright demands for accountability. This transition is manifested by the new determination to obtain utilization and cost/charge data that will enable the employer, unions, and individuals to compare physicians and hospitals by name, and thus guide provider preference.*

Taken together, these changes represent an evolution from the giving of a benefit to the management of an asset.

It is our position that the proposed prospective pricing plan for Medicare should be supported. We come to this conclusion fully aware that the proposed system addresses only some aspects of the total medical cost problem, that an increase in cost shifting may result, and that there will inevitably be further changes needed as we learn from the new system's implementation.

Changing to the prospective approach poses a major challenge to all parties in the private sector. If hospitals fail to enact the cost efficiencies that are available to them and simply try to shift any new expenses to private payers, employers will be left with no choice other than joining in the call for expanded government controls on the total system. If physicians do not significantly change practice patterns, hospitals will be left with no choice other than imposing new practice standards with decreasing flexibility. If employers, unions, and employees do not work together for benefit design reform to lessen medically unneccessary demand, not only will costs continue to rise but also the quality and appropriateness of care will continue to decrease.

We do not desire a totally governmental delivery system. We believe that diversity of systems is necessary for the innovation that made medicine in the USA the world's best. We believe that the Medicare prospective pricing system can be a major stimulus for getting costs under control, building a long overdue utilization and pricing data base, and achieving balance between regulation and price competition.

Criteria for Success

It is our position that there are several elements needed to make the prospective system a success:

1. *Utilization Review must be made part of the system. Fiscal intermediaries should not be the review group. The review should be concurrent (providing DRG verification) and will be supplemented by the Administration's plan for a sample restrospective review. Every effort should be made to develop preadmission certification programs to complement the concurrent review and retrospective analysis. We urge Congress to fund the PRO program which became law last year. This program, developed under the leadership of Senator Durenberger, is being eliminated by the Administration by the simple procedure of refusing to put it in the budget. This is in direct violation of the stated intent of Congress, and of the desire of private purchasers. Further, it will weaken their own prospective pricing program which is generally modeled on the New Jersey program in which utilization review has proven to be an essential component.*

2. *States should be allowed to apply for waivers if they develop reimbursement* ***and*** *utilization control systems that promise to be at least as cost effective as the new Medicare system itself. We must remember, if it were not for just such waivers in the past, the DRG system experiments would never have been implemented. At the state level, all payer systems, competitive bidding systems, and hybrids of those approaches should be allowed to flourish, even to fail. We should not be afraid of failure in the search for improvements. After all, it is hard to imagine a bigger failure than perpetuation of the status quo.*

3. *A final basic criteria is a full disclosure requirement for all providers, regardless of payer. Medicare utilization and pricing data must be available to all. Comparable utilization data for all other payers, physician and hospital specific, must be public. UB-82, which should be required simultaneously with the effective date of the prospective pricing systems will be an important asset in the movement of the private sector toward per-case reimbursement. The providers must realize that any further unwillingness to accept such a full disclosure requirement will result in private payers pressing for a governmentally mandated all-payer rate setting system.*

Issues and Concerns

Change of the magnitude represented by the prospective pricing proposal carries with it considerable risk and raises many issues which, while not impenetrable barriers to implementation, do deserve consideration. In the list which follows, we present our concerns, cautions, and reactions in the hope that Congress and the Administration will find these useful as the prospective pricing plan's details are developed.

1. *We do not believe hospitals or physicians should be allowed to bill Medicare patients for any charges, other than legislated cost sharing, above those paid by Medicare. Medicare patients are already responsible for more of their own costs than most who are far more financially secure. Allowing extra charges would subvert the basic principles of the prospective pricing concept.*

2. *Congress should establish the timetable by which DHHS must develop DRGs for outpatient, psychiatric, and long term care. Physician fees and the cost of capital should also be included as soon as possible. Medical education and research should remain separately funded programs.*

3. *It has been suggested that major employers can unilaterally control cost escalation in the private sector. This is not true. A primary reason for the full disclosure requirement identified above is the simple fact that even our biggest companies are, in most locations, small employers. Although they tend to grab the headlines, there are actually few cases of a company town where one, or even a few, employers dominate the hospitals. Congress needs to know this and establish the information systems that will enable purchasers of all sizes to act prudently based on sound comparative information. Employer involvement should be dependent upon knowledge, not economic muscle which itself is no guarantee of action that will be beneficial to the community as well as the company.*

4. Concern has been expressed for the quality of clinical data now on claims forms. In our view, the poor quality will diminish in direct proportion to the use of that data for reimbursement purposes. The DRG system will force hospitals to invest in better records systems and personnel. In establishing the prospective pricing system, we should not be detoured by the failure of the medical community to marry billing information with final diagnostic information. Hospitals should not seek special government financial assistance for data processing systems. Doing so would make no more sense than having the SEC pay banks to meet their reporting requirements.

5. A data issue of greater concern is raised by the use of historical utilization and pricing norms to establish the DRG rates. Virtually all national norms are much higher than need be; this problem is even greater in many local areas. Today's norms are the product of the economic incentives and traditional practice patterns we all agree must be changed. Compounding the problem is the effort, during the past several months, that many hospitals have undertaken to get their cost base as high as possible. While it is understandable that this activity would take place, the activity itself is both unethical and inflationary. Perhaps the data rates should be set on a 1981 base with a national inflation factor to avoid this hospital-by-hospital base factor loading. In addition, the problem of using old norms calls for a review and downward revision of DRG rates after the program has been in place for two or three years. This review should be separate from the other, annual rate setting procedures designed to keep the system current.

6. One of the difficulties in monitoring the impact of the DRG system is the absence of outcomes validated utilization standards. In order to make progress in this lengthy and complex task, we support the concept, espoused by Senator Baucus for a Physicians Advisory Commission on Clinical Practice.

7. Many have expressed concern that the prospective pricing proposal may result in a two-class medical care delivery system. There is no question that underservice could result and some hospitals might refuse to care for the poor and elderly. What Congress and the public must face is the reality that today we have the worst form of two-class system. We promise a simple-class system, but dash those hopes against barriers of unequal payment, explicit rationing, implicit rationing as exemplified by the AHA guidelines on how hospitals can keep out the poor, unmet Hill-Burton obligations, dumping of patients on public general hospitals...the list is

endless. In the current system, "second class" care is hard to identify, much less correct. The problem is not the quality of care practiced by the physicians, rather it is the entry system and the methods of resource allocations for the care of patients for whom reimbursement is less than the amount desired by the hospital.

DRGs and prospective pricing will neither cause nor cease the two-class problem. However, having the utilization and pricing comparative information that results from a DRG system can be a valuable tool in the hands of those — and I would include our Group in this number -- who would work for the end of the hypocrisy of our current system.

Conclusion

As private sector purchasers, we are taking a risk by supporting a Medicare-only system. We understand this but believe that too few of the details of prospective pricing are known or tested to move directly to a fully national system. We would also like to believe that, while learning from the Medicare experience, we will see a convergence of cost management forces from employers, consumers, and innovative state systems. The management tool and information base of DRG prospective pricing represents a big step in the right direction. It may also represent the final chance for a pluralistic delivery system, essentially private, that honors our public committment to quality care for all.

Senator DURENBERGER. Thank you very much.

I take it from your testimony—that you believe prospective pricing is a step in the right direction. An additional step involves the physicians directly in the process, and is in part the notion behind HMO arrangements. Why is it that we can't just skip the hospital only step and go immediately to a system where the physicians are more directly involved in the process? What if parts A and B of medicare were married into a single prospective payment?

Mr. GOLDBECK. Well, we would have no problem with the idea of marrying part A and part B. As I indicated, we do support including the physician fee within the DRG concept. At the moment we are left in the situation of accepting the word of the health services research community that there isn't an adequate data base to bring the CPT-4 procedure coding information and its rather helter-skelter development around the United States into sync immediately with the ICD-9 data base for the DRG's. Accepting that as an accurate reflection then I personally would recommend that the time schedule to develop the data base ought to be included within the legislation or else it is just going to take that much longer to have it come to fruition.

I think you were correct in expressing what is going on in the private sector. There is, albeit much too little going on in many places, the leaders, are taking much greater advantage of the kinds of information that can be obtained. They are using DRG's to target various kinds of utilization control, and actually guide patients through the system. The concept of guiding patients can be viewed as onerous and intrusive or it can be viewed as the greatest consumer asset that's ever come along. It depends on how you manage that information.

We see companies now establishing consumer information systems for their employees and retirees and dependents so that they will be taking all of the utilization data from the physicians and hospitals in a given community and making that available on a comparative procedure basis to the employee or dependent who has been identified as having the need for a particular procedure. And then they can select. They can see it makes more sense for this procedure to be done in a specific place. That information is being connected to economic incentives within the benefit design itself so that you have a company now which will pay for the following surgical procedures we will pay considerably more for the outpatient than the inpatient, which is an exact reversal of the rather obtuse incentives that existed before.

Senator **DURENBERGER**. Are we going to slow down the process of negotiating that is going on out there by moving just this one step rather than taking two or three steps?

Mr. **GOLDBECK**. No. In fact, I think you will speed it up. I cannot imagine any greater incentive to private sector employers and others to get off the dime than to be faced with the specter of medicare finally becoming a prudent purchaser.

Senator **DURENBERGER**. What else should be done? How do we arm some of the other people out there in the system with the ability to do the same kind of negotiating that employers are doing? Do you think it is a good idea to arm everybody in some way and take down the barriers so that everybody is operating on the same playing field?

Mr. **GOLDBECK**. I am not an antitrust lawyer or expert by any stretch of the imagination. I don't really know how how onerous that is for the insurance carriers. I don't believe that it is a problem for the employers because there is no necessity that a group of employers go in literally hand in hand and negotiate as one. There are ways to sequence that if one needs to. But I think the largest single thing that you can do is to create a full disclosure requirement so that anybody who is purchasing and using health care in the United States can obtain utilization, pricing, physician and hospital specific information and make their comparisons, across the country. Then we will find that people make very rational decisions about what to do. In the current system everybody is behaving very rationallly but not very successfully in terms of controlling cost increases.

Senator **DURENBERGER**. You pointed out that we should make sure we don't give hospitals the out that we are currently giving doctors with regard to their choice of not taking assignment; In other words, allowing hospitals to bill patients over and above the DRG rate. As I was sitting here this morning listening to the chairman talk with the American Medical Association, I was thinking that perhaps physicians could be asked to tighten their belts by forcing them to accept assignment on Part B. Do you have any reaction to that?

Mr. **GOLDBECK**. As an organization we do not have a formal position on that. The response in the business community 3 years ago would have considered that totally inapplicable. Today, it would receive a lot of consideration. That is the rate of change in thinking about the acceptability of certain kinds of controls. Simultaneously with the sympathy for controls there is also a growing realization that certain negotiated and restructured, reorganized, changes in the private sector incentives may also be just as effective or potentially better, in the sense that they do not rely upon a Government agency There remains a preference to stay away from the formal regulation. But, if it is not possible to move toward a system in which the commitment to provide cost efficienct medical care is met by the reality of the provision of that care then it seems to me the Government has the obligation to go ahead with the requirements that will produce the desired response.

Senator DURENBERGER. Suppose we publish a list of all those physicians with their addresses and phone numbers and medical specialties who are willing to accept the assignment under part B, would that be an appropriate reform?

Mr. GOLDBECK. I think that part of the nature of incentives is not just monetary per se but is also who knows what about whom. There is no reason in the world why those who are in need of care and are going to receive some public financial assistance shouldn't also have some assistance in terms of public information about, where to go.

Senator DURENBERGER. Well, I appreciate very much your testimony and your response to the questions.

Mr. GOLDBECK. Thank you.

Senator DURENBERGER. Thank you very much.

Our next witness will be submitting a written statement for the record. So we move now to a panel consisting of Miss Frances Klafter, chairperson of the Gray Panthers, Washington, D.C.; Mr. Jacob Clayman, president of the National Council of Senior Citizens, of Washington, D.C.; and Mr. James M. Hacking, assistant legislative counsel for the American Association of Retired Persons, Washington, D.C.

[The prepared statement of Robert M. McGlotten follows:]

83-14

STATEMENT OF ROBERT MCGLOTTEN LEGISLATIVE REPRESENTATIVE, DEPARTMENT OF LEGISLATION AMERICAN FEDERATION OF LABOR & CONGRESS OF INDUSTRIAL ORGANIZATIONS ON HOSPITAL PROSPECTIVE PAYMENT SYSTEM, BEFORE THE SENATE FINANCE SUBCOMMITTEE ON HEALTH

February 17, 1983

The AFL-CIO is pleased to have this opportunity to present its views on prospective budgeting as a solution to the serious problem of Medicare inflation. Organized labor has long been concerned about uncontrolled costs. We vigorously supported comprehensive hospital cost containment when it was under consideration by the Congress and have given strong support to similar efforts in state capitols. Our affiliates and local unions have made major efforts to get a handle on this problem through collective bargaining and participation in local health care coalitions. We commend you for convening hearings expeditiously on the Administration's plan to base reimbursment of hospitals on the cost of treatment provided to each patient. However, since there has been so much discussion and little agreement on the nature of the so-called "Medicare problem," I would like to make some general comments before discussing any of the proposed remedies.

HEALTH CARE COSTS

Hospital care is the largest (42 percent) and most rapidly expanding category of national health expenditures. For the past 6 years hospital costs have risen at an annual rate more than two times greater than increases in all other goods and services in the general economy. This rapid growth in hospital costs has had a profound effect on the Medicare program. Approximately two-thirds of total Medicare expenditures are paid to hospitals, which explains why outlays for the program are rising at an annual rate of almost 20 percent. It also explains the growing pressure to bring inflation in the Medicare program under control.

Conservative theorists blame patients for the current health care crisis. They believe that skyrocketing increases in Medicare inflation can be reduced dramatically by making individuals more "cost-conscious." We hope the Committee will not be persuaded by this unfounded rhetoric and will look at the facts. For "cost-consciousness" is a clever euphemism for less coverage and higher out-of-pocket payments for beneficiaries, while the real decision makers in the health care system, namely hospitals and physicians, continue to increase costs and raise fees without restraints.

There are three factors which determine the level of health care inflation in a given year: price, utilization and intensity. According to the Health Care Financing Administration, during the period 1967 - 1978 inflation accounted for 50 percent of the annual increase in Medicare costs. The next largest category (36 percent) was intensity of services, such as improvements in technology. Contrary to the commonly held view, non-labor costs account for 70 percent of the figure. Increases in the Medicare population account for 12 percent. The smallest category (1.9 percent) was utilization, which reflected increased demand. The problems which must be solved, therefore, are how to reduce the price of medical care and change incentives within the current reimbursement system which encourage unnecessary testing and other procedures. Despite present efforts to reduce Medicare coverage, unless we can bring inflation, excessive testiing and unnecessary surgery under control, there will be no end to rising expenditures.

In this connection, Mr. Chairman, I would like to address an issue which is repeatedly misrepresented. That is, the impact health care workers have on health care costs. Most health care workers have been and continue to be, underpaid. According to the Bureau of Labor Statistics, non-supervisory health care workers earn almost 15 percent less than workers in other industries. Their real income has been declining and in 1980 was 6 percent lowers than in 1972. In effect, hospital workers have been unfortunate scapegoats for the real villains in the health care system. Everyone in this room has heard workers being blamed for health care inflation. Yet from 1965 to 1980 wages, as a percent of total expenses in community hospitals, declined from 62 to 49 percent. Contributions for fringe benefits also declined.

The point is there are no easy answers to the problem of rising health care costs. Mr. Chairman, the AFL-CIO urges this Committee to be skeptical of those who blame our current health care crisis on those who work in and are served by the health care system. For until the providers and suppliers of health services have real incentives for cost effective behavior, as a nation we will continue to pay a great deal more for less.

REIMBURSEMENT OF HEALTH CARE PROVIDERS

For some years the AFL-CIO has thought the health care system poorly managed and that incentives which would make hospitals more cost-conscious ought to be added to public and private health insurance programs. However, we believe a cost containment system ought to apply to all payors and include all providers, including physician services. In addition, and perhaps most important, no cost containment system should worsen the already unequal balance between the haves and the have-nots in our system.

Organized labor supports the Administration's plans to introduce the concept of prospective budgeting into the Medicare system and to discontinue the practice of paying hospitals whatever they spend. We regard the proposal as an improvement over the present practice in Medicare of rewarding inefficient hospitals and penalizing facilities which have tried to contain costs. We fully support the Administration's decision to prevent hopsitals from passing on to Medicare beneficiaries any reductions in reimbursement. We do not believe a nationwide system based on so-called diagnostic related groups (DRGs) is the best answer. We believe the jury is still out on the New Jersey system, which has been the model for this proposal. We do not know enough about the effectiveness of this approach to adopt it immediately for Medicare. In addition, there are many problems associated with implementing a DRG system that the proposal does not address.

In the Executive Summary of the Administration's report to Congress outlining its DRG proposal there are listed four goals which the program is expected to accomplish: 1) improve hospital efficiency; 2) make Medicare a prudent buyer of services; 3) reduce administrative burdens; and 4) assure beneficiaries access to quality health care. Although the proposed plan may in some respects be an improvement over the present system, there is no evidence it will meet these expectations. In fact the opposite may be true. Without strong utilization controls in the proposed system, Medicare costs could increase. Unless outpatient services are included, the Administration's plan will only add to hospitals' already cumbersome paperwork requirements by requiring hospitals to keep one set of books for outpatient services and another separate set for inpatient services.

A prospective reimbursement system for Medicare alone would give hospitals strong incentives to turn away all, or certain types of, Medicare patients. We agree with the insurance industry that it could also encourage facilities to shift unreimbursed costs onto employees, employers and already overburdened state and local governments. A far better course would be enactment of a comprehensive all-payors cost containment system, which would allow states meeting federal performance standards to make their own decisions about the system of prospective reimbursement which should be used by all insurers, including Medicare, to reimburse providers. I will go into greater detail about the structure of such a program later on in my testimony. At this time I would like to list organized labor's concerns about the Administration's DRG proposal.

PROBLEMS ASSOCIATED WITH DRGS

Cost of the Plan

Several months ago the Wall Street Journal published a story evaluating New Jersey's experience with DRGs. The President of the New Jersey Hospital Association, Louis Scibetter, described the system as an "administrative nightmare," which was not cost-effective. A 1981 survey of the first 26 hospitals to enter the system indicated that most administrators could not determine whether the new system was having a positive effect on health care costs. In fact, 40 percent of statewide hospital claims are now paid on the basis of exceptions which does not bode well for the efficacy of a DRG system.

A major concern with the Administration's proposal is whether it will result in higher Medicare costs. The DRG system involves placing patients for purposes of Medicare reimbursement into one of 467 diagnostic categories. This involves a great deal of discretion on the part of physicians who would be making these decisions and would encourage physicians to put patients into the highest possible category, a phenomenon which has come to be known as "DRG creep." The Administration claims it can prevent this but has not proposed any specific plan for utilization review. Therefore, it would be extremely difficult to monitor the system or develop ways to assure that this practice does not increase costs.

Cost Shifting

As efforts to control increases in health expenditures under public programs have increased, hospitals have had stronger financial incentives to transfer to other payors excess costs incurred under Medicare. In recent testimony before the Social Security Advisory Council the American Hospital Association acknowledged that many facilities have no alternative but to shift costs onto those covered by private insurance. In other words, the government has been reducing federal outlays for Medicare at the expense of financially overburdened working men and women and state and local governments. The insurance industry has estimated that in Minneapolis cost-shifting has added $33 per day to the cost of an average hospital stay.

The open-ended reimbursement system under private insurance which the Administration's proposal would not affect allows cost-shifting to take place. Hospitals have no incentive to become more efficient as long as they can cover their Medicare losses by charging non-public patients more.

Public and Inner City Hospitals

The AFL-CIO and its affiliates are very concerned about the effect of the Administration's proposed prospective payment plan on public and inner city facilities. Public hospitals have proportionately more older and sicker patients and are the providers of last resort for patients whom other hospitals refuse to treat. In recent years public hospitals have had to absorb the cost of treating a growing number of individuals who have lost health insurance coverage as a result of layoff. In many communities public and inner city hospitals are the only providers of tertiary care, such as burn units and trauma centers, and alcoholism and drug abuse treatment. These facilities are key providers of primary care and the training ground for 40 percent of all physicians and dentists. Most important, public hospitals are the medical facilities of last resort for the poor, the elderly and the jobless. Their role in the current economic recession is more important than ever.

Despite the range of health services they offer and their important role as community providers, the financial position of public hospitals is deteriorating rapidly. Yet, in terms of standard measurements of efficiency, they are far ahead of other hospitals. Inflation for public hospitals is 33 percent less than the rate of increase for all other facilities. According to Larry Gage, Executive Director of the Public Hospital Association, these facilities have reduced their lengths of stay, have increased occupancy and have reduced their bed supply by 22 percent from 1970-1980.

Rather than rewarding these essential community providers for their efficiency, the Administration's DRG proposal would only worsen their bleak financial situation. Public hospitals serve a patient population which requires more admissions, longer lengths of stay and greater intensity of services. Since DRGs are based on average costs per diagnosis, public hospitals which serve a relatively large number of patients with multiple conditions and/or complications and therefore higher costs, will be penalized. Nor will they be able to cope with growing demand as a result of more people losing coverage due to layoff.

Public hospitals do not dump patients who are expensive to treat on other hospitals. They serve all patients who need care, regardless of their ability to pay. At the same time their support from federal, state and local governments is declining. Clearly a comprehensive long-term strategy must be developed for our public hospitals. Both Medicare and Medicaid reimburse hospitals for capital costs. Non-public hospitals have used these funds to expand and modernize their facilities and equipment. Public hospitals are more likely to use these funds to cover operating deficits which are four times higher than those in private facilities. In the short run there are important steps that Congress can take to assure that any changes made in the Medicare reimbursement system do not unfairly penalize essential community providers.

In Section 101 of the Tax Equity and Responsibility Act, the Secretary of HHS was authorized to make adjustments in reimbursement to public and inner city hospitals. To date the Department has not implemented this adjustment but has spent its time trying to prove whether it is needed. Meanwhile more and more of these facilities are approaching bankruptcy. Congress should immediately pass legislation instructing the Secretary to give facilities which serve higher than average numbers of Medicare and Medicaid patients a special allowance. This adjustment should also be incorporated in any long-term prospective system. An all-payor prospective reimbursement system, which included a bad debt and charity allowance, would also relieve the financial burden on public hospitals.

Teaching and Capital Costs

The Administration's proposal would allow hospitals to pass through teaching and capital costs. Yet these are areas that have played a significant role in increasing the cost of medical care. Certainly hospitals need capital allowances. However, unless the reimbursement system provides incentives to economize in this area, no significant savings will be achieved.

HMOs

The DRG program would mean higher costs for HMOs. Since hospitals would be paid on the basis of average costs, there would be no rewards for preadmission testing or reduced lengths of stay. In fact, available evidence indicates that in New Jersey since the advent of the DRG system, HMOs have had to make higher payments to hospitals for the same services than before DRG came into effect.

If the objective is to reduce Medicare expenditures, we should accomplish this without increasing the costs of effective alternative delivery systems. Organized labor recommends, therefore, that HMOs which can demonstrate cost-effecitveness ought to be exempted from the prospective budgeting system.

RECOMMENDATIONS

The AFL-CIO urges the Committee to adopt a prospective reimbursement system for all payors, public and private, with flexibility for states to design their own systems as long as they meet federally established guidelines. Organized labor fully supports the HALT proposal developed by the Health Security Action Council (HSAC). This proposal is attached to our testimony for your review.

As the Committee examines alternatives to the present method of paying hospitals and the factors which contribute to 20 percent annual increases in Medicare expenditures, we urge you to also look at the adequacy of the Medicare benefit package.

In addition to its DRG proposal, the Administration has recommended increasing beneficiary cost-sharing as a way of bringing Medicare inflation under control. Since physicians decide who goes into hospitals, how many tests they have and when they are discharged, there is a great deal of uncertainty as to whether the Administration's budget proposals, if adopted, would save money. There is no doubt, however, that these proposals would be a cruel blow to senior citizens who have already been asked to accept a six month delay in their cost-of-living (COLA). For example, the average widow on social security would have to spend almost $600 out-of-pocket for an average hospital stay, which amounts to almost two months of her social security benefits. The same individual would be required to pay 20-25 percent of her annual cash benefits before being eligible for catastrophic care.

A far better course, which would reduce Medicare expenditures in the long run, would be to lower the cost-sharing that beneficiaries are required to pay for outpatient physician services and to expand Medicare benefits to cover drugs, dental care and other services which keep older people healthier and reduce their need for hospital care.

CONCLUSION

The present problems associated with high inflation, reduced access and uneven quality of care would not exist had Congress enacted national health insurance, as the AFL-CIO has long recommended. We will continue to work toward the goal of national health insurance. But organized labor believes we cannot wait to bring health care inflation under control.

We also urge Congress to reject the Reagan Administration's proposed budget cuts in the area of health care, which would penalize beneficiaries and discourage them from seeking needed health care treatment while allowing the providers and suppliers of services to increase cost at uncontrollable rates. Instead we urge Congress to immediately enact a comprehensive cost containment program for all payors and including physician services.

THE HEALTH SECURITY ACTION COUNCIL

HEALTH CARE COST CONTAINMENT - A CONSTRUCTIVE APPROACH

April 1, 1982

The program herein outlined is a major alternative to the cuts in health programs proposed in the President's Budget.

Labor, business, civic, fraternal, religious, senior citizen and farm organizations, as well as, national and local political leadership agree that skyrocketing health care costs must be brought under control. Last year health costs increased 15.3% over the previous year. This was the highest in our history. This is unacceptable.

This is a national problem. It is not only a problem for the public sector. It is a problem for the private sector as well.

The Administration's approach would again slash Medicare and Medicaid programs, wiping out vital services for millions of children, the disabled and the elderly, while simultaneously shifting the cost of their care to the rest of the economy.

In addition they have been proposing a so-called "competition" proposal. It claims to offer control of health care costs by placing a ceiling on employer and/or employee payments for health insurance. But this plan would not contain costs. It would shift them, through reducing health coverage and transferring charges from insurance to consumers and patients. A tax gimmick would be used to abandon hard-won, high option health insurance plans for lower-grade coverage. A variant of the plan, involving Medicare vouchers, would diminish already inadequate health care protection for millions of elderly and severly disabled persons.

As a national problem, skyrocketing health care costs demand a national solution. Although a comprehensive national health insurance program would be the best solution, it is not a politically viable one for 1982.

Consequently, the next best solution is equitably to control and rationalize health care spending within our present insurance system. Such a program would require equal constraints on the public and private sector, and on the providers and insurers of services.

This solution would deal with all of the principal elements of the health care system. Moreover, it would decentralize many of the critical health cost containment decisions to the state level, with the federal government providing broad guidelines, standards and technical support. If a state is unable to undertake such a program, the federal government could make it available.

In the name of cost containment the Administration is proposing to reduce the federal deficit by shifting billions of dollars from the federal government to patients, doctors, hospitals, private insurance, and already overburdened state and local governments. This approach will not contain costs; it will only cause added suffering and death due to slashed services and entitlements.

There is a better way, a more humane approach, that will protect people and save money. That is why a new comprehensive alternative to the Administration's plan is being proposed.

It would put an immediate brake on health cost escalation, while a new series of state controls, based on prospective budgets and negotiated agreements with providers, insurers and other payors are put in place.

The program will save an estimated five and a half billion dollars in public expenditures in each of the first two years of operation. Of these savings, some one and a half billion dollars would be returned to the states as incentive payments under Medicaid.

The private sector would also benefit. It would be expected to spend annually some seven and a half billions dollars less, without reducing benefits, under this plan, than if the Administration's proposals were adopted.

The new program can effectively begin to produce needed changes, and at the same time protect the consumer. Drafted by an advisory group of professional and technical experts, it contains the following principal features:

1. Comprehensive cost containment across the entire system - public and private, including hospitals, nursing homes and professional providers of health services.

2. State responsibility and flexibility in the cost control process, combined with prospective budgeting and ceilings on hospital and nursing home payments, based on the previous year's expenditures plus increases allowed for the rate of inflation in the economy.

3. In the first 2 years of the plan the state ceiling would be set by the state in accordance with the previously enunciated principle This would almost cut in half the rate of escalation

of health care costs. Further, it would assure the continuation of the present benefits and entitlements of public programs.

4. Physicians and other professional providers' reimbursements would initially be held to current levels, plus an allowance for inflation in cost of office overhead. Providers could not charge above negotiated reimbursement rates for in-hospital and nursing home services ("assignment").

5. Laboratory and x-ray services would be reimbursed on a negotiated rate schedule worked out among representatives of the public agencies, Medicare intermediaries, providers, insurance companies, consumers, and the laboratories and x-ray organizations.

6. The organization of new health maintenance organizations would be encouraged.

7. A national expert committee would advise the professions and the payors on new procedures and new technology.

8. New programs for more effectively meeting the long term care needs for the elderly and disabled would be encouraged.

Details of the specific proposals are contained in the section which follows.

Hospitals

Since hospitals are the largest single source of personal health expenditures, public and private, control of the increase in their costs would be central to the new comprehensive health cost containment system.

The principal feature of the new program would be a state prospective budgeting system with annual ceilings for both hospitals and nursing homes. Together they constitute almost half of current payments for personal health services. The total budget for state expenditures for hospitals, public and private, but excluding state mental hospitals, would be based on: a) the last year's total expenditures; or b) a typical year in the last three years; or c) the average of the previous three years' expenditures. This would be adjusted by the increase in the Consumer Price Index in the past year.

The percentage increase allowed would be uniform for both public and private sector payment of costs and/or reimbursement. The Federal and state governments would continue to receive discounts which derive from their positions as the major purchasers of hospital services.

Each of the principal payors for hospital care, including Medicare and Medicaid, would be limited in its payments by its previous proportion of hospital care payments to total state spending for hospital care. Annual adjustment would be made for the number of persons enrolled in the programs, their age and health status. The uninsured and others paying out-of-pocket for hospital care would pay directly to the hospital involved with appropriate credit given in hospital budgets for such payments.

Federal Medicare and Medicaid funds would provide the leverage for the new system in each state. The law would require however that private insurance payments, including Blue Cross, would be mandated for inclusion in each state program.

Medicare would continue as a Federal program with full control on eligibility and benefits, and through intermediaries, would continue to monitor program operations to assure the proper implementation of Federal law and policies.

The key to cost control would be however with the states which are closer to the actual delivery system and in a better position to see that the system is both cost efficient and effective.

The states could, as long as they remained within the predetermined ceilings, use their own methods of determining how to pay hospitals within the system. This could be done in a variety of ways: prospective budgeting by category of hospital (e.g. teaching hospital, small, medium or large community hospital, rural hospital, etc.); formulae to set limits on what could be charged various payors; budget reviews of each hospital; capitation payments for defined populations.

State flexibility in adopting their own budgeting plans would be assured, so long as they were based on prospective budgeting and annual predetermined ceilings.

Representatives of health workers would participate in the state wide reimbursement negotiations on an equal basis with hospitals and nursing home officials and the plan would protect collectively bargained rights and benefits for employees.

A State agency, either responsible to the governor directly, or as a semi-autonomous unit in the State Health Department, would manage the program and be responsible for negotiations with the hospitals and the insurers and would proyide for adequate consumer representation.

Each state would be required, within 120 days of passage of federal legislation establishing the program, to file with the Department of Health and Human Services notice of intent to operate the cost containment plan. The state would enact implementing legislation. Its plan would be subject to approval by the Department of Health and Human Services.

There would be a federal appeal mechanism which the state could use in the event of disagreement regarding Federal plan approval. Similarly there would be a state appeal mechanism for hospitals and payors (insurance companies, Blues, HMOs) which may have disagreements with the state administrative agency.

Savings from the negotiated budget would be shared by the hospitals, public and private payors. Consumers would participate in the savings through improved services and lower insurance premium rates made possible by hospital cost savings.

Prospective budgeting is a simpler way of reimbursing hospitals than the currently prevailing cost reimbursement system. Therefore, it should yield considerable savings in lowered administrative & recordkeeping costs. At least part of these savings may be required for added allowances for hospitals which serve disproportionately large numbers of the medically indigent for whom no (or reduced) public payments are available.

In negotiating the annual prospective budget the parties would be expected to take into account the need for reduction in duplicate services and excess plant capacity, as well as appropriate planning for changes in technological and physical resources.

States which participate in the program would have the incentive of an approximately 10% reduction in their contributions of Medicaid funds in the coming year. These reductions would be financed from the reimbursement savings engendered by the operation of the cost containment plan.

Since it would in all likelihood take a year or more to make this health care cost containment program fully operative, hospitals would be required to operate for 24 months under a fixed reimbursement formula, adjusted for inflation, as described earlier. Charges and cost reimbursement per patient and charges per procedure in the first year would be fixed at the mean of similar charges for the hospital in the previous 12 month period, plus the increase in the Consumer Price Index for the same period. A further adjustment in reimbursement would allow for any increases in the wages and benefits of non-supervisory employees during the transition period.

In the second year increases up to two-thirds of the increase in the CPI for the previous year would be permitted.

Hospitals could shorten the period of fixed reimbursement rates to 12 months in any state where the plan could be readied for operation in a period less than 24 months.

Nursing Homes

Nursing homes and intermediate care facilities continue to require major and increasing expenditures from Medicare and Medicaid as well as private sector programs. Despite the fact that some 80% of the beds are operated by private for profit owners, competition has not played a meaningful role in containing increases in costs.

Cost containment is essential, but it must not jeopardize decent staffing and facility standards. Unless adequate standards are maintained, quality of care and competence of staff would be eroded.

Accordingly, the state agency charged with administering the hospital program, along with the Medicare intermediary, would also be required to see that existing Federal and state standards are observed within the same prospective budgeting limits as are required of hospitals.

Provisions which apply to hospitals with regard to negotiation of budgets, appeals, savings from budget, employee protections and the maximum 24 months restriction on price increases would apply to nursing homes and intermediate care facilities.

In negotiating the annual prospective budget the parties would be expected to take into account the need for reduction in duplicate services, excess plant capacity, and appropriate planning for expansion of technological and physical resources.

Physicians and Other Providers

Existing reimbursement methods contribute to inflated health care costs by encouraging procedures and discriminating against services that do not involve technology. They fuel cost increases by reimbursing on the basis of charges that are not the result of negotiation among payors, patients and providers.

Under the Health Care Cost Containment Plan, third party payors, including states, insurance companies and third party intermediaries in behalf of Medicare, organized labor, representatives of the public, and representatives of physicians and other independent health professionals would negotiate annual fee schedules or alternative payment arrangements that would be used for reimbursement.

Initially fee schedules would be set at present levels in each of the three programs in the state (Medicare, Medicaid, private insurance). A single level fee schedule is obviously preferable, but would probably be too costly to the public programs in the initial and transition stages. Hopefully, over time, through joint efforts of the parties involved in the state negotiations, movement would be made toward a single schedule or reimbursement arrangement which would be equitable for providers and payors.

Incentives would be built into the payment structure to encourage primary care, disease prevention, and health promotion, and to give appropriate compensation for treatments which are time and process oriented.

The Health Care Cost Containment Program would mandate "assignment" for in-hospital and nursing home services. Providers could not charge above negotiated reimbursement rates. Professional services delivered in these institutions, as well as their nature and frequency, are sufficiently different from ambulatory services to require both a different payment structure and one that reflects total payment.

Since it would in all likelihood take a year or more to make the health provider cost containment program fully effective, states would be authorized to provide for no increases in rates of reimbursement for health providers for a twenty-four month maximum period, except for an allowance for increased overhead costs reflecting the year's inflation rate. Provision would be made for relaxation of these fixed rates after one year if in any state the system could be placed in operation sooner.

Third party payors and the health professionals should be encouraged to develop capitation and other payment arrangements and to be reimbursed on other than a fee-for-service basis. It would be appropriate and desirable for payors, patients and providers to benefit from these savings.

In arriving at appropriate reimbursement schedules due recognition should be given to the cost experience of the previous three years, to adjustment necessary because of anticipated inflation, changes in demographic characteristics of states and local areas, etc.

Payment mechanisms or fee schedules arrived at through negotiation are not designed to reduce compensation of health professionals, but to begin the process of instituting cost increase restraints.

Existing payment patterns in Medicare and some private insurance programs (particularly indemnity insurance) do not provide for full payment for professional services. Accordingly these underpayments are made up by out of pocket payments by patients. Provisions would be made in state requirements that such out of pocket payments could not be increased to make up for the constraints in reimbursements in professional fees.

Laboratory and X-Ray Services

Each state would appoint a laboratory and x-ray payment committee under the Health Care Cost Containment Agency. It would be composed of representatives of the public agency, Medicare, providers, insurance companies, consumers, and the laboratory and x-ray providers. Fee schedules would be developed annually and payments made on this basis. The Committee would be empowered to review appropriateness and frequency of the procedures and technology used.

Health Maintenance Organizations

Separate contracts would be negotiated with HMOs offering them maximum reimbursement up to prevailing costs in the area adjusted by age and health status. The objective would be to avoid selective enrollment of favorable risks.

Unions, employers and insurers would be encouraged to organize new HMOs. Partial forgiveness, up to a stipulated maximum of first year organizing costs of new non-profit HMOs would be provided through provision for write-off as a business expense, or payment of an extra 5% in premiums in each of the first three years of operation.

New Procedures - New Technology

New procedures and new technology have brought important health benefits to millions of Americans. To reduce future costs by denying the fruits of research to future patients is unconscionable. But the fact is that unless we find ways of assuring that new procedures are paid for only when they are appropriately used and that less efficacious procedures are phased out, we will find ourselves unable to finance desirable advances.

The issue of appropriate use of new procedures can, in part, be addressed through fee schedules and other organized payment arrangements. But the refined information needed must be of the highest quality, and the decisions to be taken require professional concensus and acceptance. The national program will therefore authorize organization of a Professional Advisory Committee on New Procedures and Technology sponsored by the Institute of Medicine of the National Academy of Sciences, or within tne Department of Health and Human Services, and supported by existing professional bodies. This committee would be given the responsibility to examine the appropriateness of various interventions and the conditions under which they are needed. The efficacy of alternative theraputic regimens, the standards for availability and utilization of various technologies would be reviewed and commented on. The Committee's reports would be advisory to the health professions, administrators of institutions, payors, and those who negotiate payment schedules and prospective reimbursement.

Long Term Care

Meeting the needs for long term care for significant numbers of people, particularly the elderly, continues to be a vexing, expensive and largely unmet issue in health care and in social services.

There is widespread agreement that present patterns of services are often inappropriate, and unduly costly.

Proposed solutions which do not involve large new expenditures are not readily apparent. There is however considerable agreement on at least two principles: 1) Many more chronically ill and severely disabled could and should be cared for at home if appropriate services could be brought to them. Experienced personnel in institutions should be used for many of these home care services. 2) The chronically ill and severely disabled could and should have available to them a combination of health and social services which the present compartmentalization of public programs makes it difficult, if not impossible, to provide.

Accordingly it is proposed that the health care cost containment plan authorize states desiring to do so, to take up to a stipulated percentage of Title XX funds and a percentage of Medicaid funds, to support demonstration projects designed to maintain the chronically ill and severely disabled outside institutions. Continuity of care should be safeguarded through delivery of many of the services by institutional personnel with appropriate contractual protections. Plans like "social HMOs" or "personal care organizations" would thus be encouraged to develop more progressive and possibly cost effective patterns of long term care. Such demonstration projects are more likely to prove meaningful when developed at the local level by knowle knowledgeable people with understanding and a caring attitude about the problem.

In Conclusion

This Health Care Cost Containment Plan is realistic and achieveable within a reasonably short period of time. It would take courage on the part of the Congress to initiate it, for it represents a fresh approach to dealing with the escalation of costs of health care.

This plan would require formulation in legislation. Preliminary estimates of savings involved, however, are so substantial that full implementation would, in F.Y. 1983, make possible:

1) Savings in Federal budget expenditures for Medicare, Medicaid and other personal health services programs comparable to those proposed by the Administration for F.Y. 1983. These, however, would be achieved without further slashes in eligibility or benefits.

2) Beginning relief to the states of constantly increasing expenditures for Medicaid programs without further reducing eligibility or benefits. Approximately 1.5 billion dollars in relief to the states would be expected in each of the first two years.

3) Some 7.5 billion dollars per year savings in insurance and out of pocket payments in the private sector in each year of this plan as compared with the continuation of the status quo.

4) A return to the states of needed initiative and authority to control health costs in their jurisdictions.

5) A halt to cost shifting from federal programs to the private sector, to states and to patients and adequate protections for health care workers.

6) The initiation of sound long range plans for continuing containment of health care costs in both the public and private sectors.

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February 10, 1983

The Honorable David Durenberger, Chairman
Subcommittee on Health
Committee on Finance
United States Senate
2207 Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Chairman:

It is our understanding that the American Federation of Labor and Congress of Industrial Organizations will be presenting testimony to the Subcommittee on Health, relative to the Administration's proposals for prospective payments under Medicare.

This is to inform you that the views which will be presented by the AFL-CIO are fully supported by Save Our Security.

SOS is a nationwide coalition of more than 140 organizations representing a cross-section of American life. I am attaching a list of the affiliated organizations to give you the full flavor of the coalition. There are organizations representing the elderly and the disabled, trade unions representing workers in the public and private sectors, social welfare groups, women's groups, civil rights groups and religious organizations. Together, these affiliated organizations have a membership of between 35 and 40 million adult Americans, almost equally divided between beneficiaries of, and contributors to, Social Security.

On behalf of Save Our Security, we wish to associate ourselves with the views expressed by the AFL-CIO, and respectfully request that this letter be made a part of the Subcommittee's hearings record.

Sincerely,

Wilbur J. Cohen

Wilbur J. Cohen
Chair

WJC/as

Senator DURENBERGER. I believe most of you have been here, some of you for the better part of the day, others this afternoon. So you have some flavor for the variety of testimony that we have been receiving.

I do appreciate the fact that everyone—even though there are differences in the testimony and differences of opinion about the administration's proposal—has been very positive in the way they have approached this issue.

We appreciate your being here and the efforts that your organizations have made in putting together your testimony.

We might as well start in the order of introduction unless you prefer going in some other order.

STATEMENT OF MS. FRANCES KLAFTER, CHAIRPERSON, NATIONAL HEALTH TASK FORCE, GRAY PANTHERS, WASHINGTON, D.C.

Ms. KLAFTER. I am Frances Klafter and I am speaking for the Gray Panthers. I head the National Health Task Force of the Gray Panthers. I am going to make a very brief statement. I have submitted a statement for the record.

We thank you for the opportunity to be here today. I want to say that we as an organization have been very impressed with the precaution with which the Congress has been moving on this issue. Most of us have sat in on lots of hearings and briefings in the last few weeks, and we think that this is terribly important. We hope you will not think that we are oversentimental if we bring in the image here of the elderly who will be lying ill in hospital beds and whose welfare and wellbeing we think could well depend on the decision that the Congress makes in this matter.

We think that the plan adopted must assure quality control in order to protect the health and welfare of the Medicare beneficiaries. And as my statement has said, we think, as written, it does not give adequate assurance of quality care.

We have been very concerned that, almost simultaneously with the issuance of this proposal the Department of Health and Human Services has issued revised regulations for the conditions of participation in medicare and medicaid that we believe would greatly weaken those regulations and would affect the health and welfare of the patients. And these things alarm us. It alarms us somewhat too that it seems to us that a great deal more attention has been given to monitoring the effect on cost in this proposed system than has been given to the effect on beneficiaries. Of course, we know that the beneficiaries are affected by costs and will be deprived of benefits if the costs continue to rise. But we think that it must be remembered that at the center of this are this nation's elderly ill in need of hospitalization.

We do not want to see medicare beneficiaries reduced to a status of second class patients. We have long taken up the cudgels for medicaid beneficiaries who were treated in that way, who were humiliated, embarrassed, denied access to care. We do not now want to find ourselves in that situation. We think it can be avoided.

From all that we have read and from the briefings we have attended we are convinced that in order to avoid discrimination and, actually, in order to effectively control costs, there must be some kind of an all-payor system. I do not pretend to be an expert that could tell you what kind of an all-payor system this must be. But we have been interested in Congressman Ron Wyden's bill that would provide for an all-payor system and flexibility for a different system in different States, where other systems have worked well.

In closing, I want to say that we trust that these considerations will be very carefully held in mind by this subcommittee—and we have every reason to think that they will be—so that the welfare of the Medicare beneficiaries will be protected. Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Frances Klafter follows:]

STATEMENT OF FRANCES KLAFTER, CHAIRPERSON, NATIONAL HEALTH TASK FORCE, GRAY PANTHERS, BEFORE THE SUBCOMMITTEE ON HEALTH, SENATE COMMITTEE ON FINANCE, ON THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM PROPOSED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, FEBRUARY 17, 1983

Thank you for the opportunity to participate in this hearing.

I am Frances Klafter, speaking for the Gray Panthers. I work as a volunteer, helping to organize a nationwide grassroots health advocacy network. I have been a Medicare beneficiary for about nine years.

The Gray Panthers congratulate this Subcommittee, first, for the part it played in passage of the legislation mandating a prospective reimbursement system for hospital services to Medicare beneficiaries, and second, for moving with caution to assure that the payment system adopted is an effective one.

We have viewed with alarm the breakdown of the health care system in terms of its ability to provide good health care to the majority of the population. Health insurance premiums keep going up, benefits down. Clinics and hospitals keep closing, without regard to the need for them, but in terms of whether they are "cost effective." The victims are those who are deprived of health care, and, increasingly, that includes many beneficiaries of the open-ended government health care programs--Medicare and Medicaid--which have held out standing invitations to the providers to help themselves at the public expense. We do not now want a payment system to be adopted that will victimize the beneficiaries further.

The staff of the Health Care Financing Administration has obviously put a great deal of time, effort and thought into the reimbursement proposal they have presented. The concerns that I express here about this proposal are certainly not original--they have been expressed many times over in hearings and briefings about the proposal, not only by advocates for the elderly but by others seeking to assure quality of care for patients in the nation's hospitals. Nonetheless I feel impelled to make this brief statement about what we view as a threat to the health of Medicare beneficiaries.

We question whether the patients whom changes in the reimbursement system should be designed to serve--the nation's elderly parents, grandparents, aunts and uncles lying ill in hospitals--will be assured quality health care under the proposed plan. We question further its effectiveness in containing hospital costs in its present form.

As to quality of care, when questions have been raised with representatives of the Department of Health and Human Services about the danger of too early release of patients, they have pointed out that fear of malpractice suits would be a great deterrent to this. We do not consider this an adequate safeguard. Furthermore, our fears of inadequate quality control are intensified by the fact that at the very time that a system is being proposed that would give hospitals an economic incentive to provide a minimum of patient care, the Department has also issued proposed revisions of regulations for conditions of participation of hospitals in the Medicare and Medicaid programs. These proposed revisions, we believe, would threaten the health and safety of patients in the nation's hospitals. We insist that enforcement of strong regulations to insure quality of patient care should not be axed in the name of cost containment.

A further concern, which has to do with both quality of care and the effectiveness of the proposed system in containing costs, is the fact that, as presented, it would cover Medicare only.

We do not want Medicare beneficiaries to become second-class patients. We have long been trying to help protect Medicaid patients from the kind of humiliation, rejection and limitation on access to quality care being second-class patients entails. We do not now want Medicare patients to suffer that fate.

We also join in questioning the danger of cost-shifting to other payors in a reimbursement system that would regulate hospital charges for Medicare beneficiaries only.

It seems clear that a hospital reimbursement system that will avoid discrimination against one group of patients and will be truly effective in controlling charges, must include all payors--Medicare, Medicaid and private insurers. We realize that there are problems involved in implementing such a system, but these problems have apparently been surmounted in those states where prospective reimbursement systems have been the most effective. We also note that Congressman Ron Wyden's Medicare Reform Payment Bill, HR 1227, recognizes the necessity of including all payors in an effective system of hospital prospective reimbursement.

The Gray Panthers have long been critics of our increasingly chaotic fee-for-service health care system, and firmly believe that the ills of the present system cannot be cured, but that we must take health care out of the market place, and replace it by a not-for-profit system, such as a national health service. In the meantime, we look to you to protect the still quite inadequate benefits of the Medicare beneficiaries.

Senator DURENBERGER. Mr. Clayman.

STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, D.C.

Mr. CLAYMAN. Mr. Chairman and members of the committee I have with me Janet Weider who is our associate research director. I would like to place our statement in the record because I am going to bobtail it I think.

Senator DURENBERGER. Everyone's written statements will be made a part of the record and you may abbreviate it.

[The prepared statement of Mr. Clayman follows:]

Medicare Prospective Payment to Hospitals

Statement by

Jacob Clayman, President
National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C. 20005

before the U.S. Senate Finance Committee
Subcommittee on Health

February 17, 1983

Mr. Chairman, members of the Committee, I am Jacob Clayman, President of the National Council of Senior Citizens. The National Council is a membership organization which represents over four and one-half million older persons through 4,500 clubs and councils in every state. The majority of our members are Medicare beneficiaries who will be affected by the changes in Medicare reimbursement which this Subcommittee is considering. We appreciate the opportunity to share with you our views on prospective payment to hospitals.

The National Council of Senior Citizens was founded twenty years ago during the fight for enactment of a national health plan for the elderly--Medicare. Since that time, NCSC has been in the forefront of efforts to improve and preserve Medicare as well as to assure that our country's health care delivery and financing systems adequately serve people of all ages.

Mr. Chairman, the National Council of Senior Citizens has appeared before this Subcommittee on numerous occasions to discuss Medicare from the beneficiary's perspective. During the past two years in particular, in an environment of severe federal budgetary constraint, our message to you has been: the elderly have extraordinary health care needs and expenses of which the Medicare program covers only a portion. Whatever program or policy changes you recommend or adopt, we urge you to consider the shortcomings of Medicare for the beneficiaries and any impacts these changes may have on them. Today I underscore this message.

This panel is addressing one of the most serious problems in our health care system and the Medicare program: the cost of hospital care. While there seems to be increasing agreement about the major causes and effects of rising hospital costs, there has been less agreement on what will solve the problem. Therefore, no effective cost-savings plan has been adopted to date. In addition, Medicare-only reimbursement reductions have not lowered costs, but have just shifted them. What effect the reimbursement limits enacted through the Tax Equity and Fiscal Responsibility Act (TEFRA) will have on hospital costs has not been demonstrated yet in the short time these limits have been in place.

There seems to be widespread agreement that the open-ended, retrospective, institutionally biased reimbursement model prevalent throughout the health care system is the major force driving up the cost of health care. This system encourages spending on the more expensive services such as hospital and other institutional care while leaving gaps in coverage of other less costly but necessary services. The system, moreover, rewards provider spending and inefficiency rather than cost-consciousness and efficiency.

Needless to say, this reimbursement arrangement has produced problems which seriously affect all participants in the health care system, as well as elements outside of the system. The problem that the Committee is addressing is how this system affects Medicare and what Congress should do about it.

Retrospective reimbursement, the basis of Medicare payment, drives up the cost of the Medicare program, but these rising costs actually represent a problem within a problem. Congress must recognize that many of the problems in Medicare reflect those which prevail throughout the health care system. Therefore, to effectively solve Medicare's financial difficulties, Congress must also address the larger health system problems. To do so requires an understanding of the dynamics within and outside of Medicare.

Some of the elements straining Medicare financing and benefit adequacy are:

- Highly inflated hospital costs are pushing up Medicare program costs. While the CPI for 1982 was 3.9 percent, hospital inflation was 12.6 percent. Over the past three years, hospital inflation has caused Part A expenditures to increase an average 19 percent each year.
- The disproportionate Medicare spending on hospital care, which accounts for nearly 75 percent of Medicare expenditures, consumes resources which should be available for non-hospital care.
- Rising Medicare program and overall health care costs are steadily eroding the adequacy of Medicare benefits and preclude payment for needed services not currently covered. Consequently, beneficiaries incur increasingly larger out-of-pocket expenditures.
- The size of the Medicare budget has made the program a target of the Administration's budget/deficit reducing strategies. These strategies have simply decreased the federal commitment and disregarded such vital elements as current benefit inadequacy, real causes of cost increases, and the growing financial burden on the beneficiary.

Medicare problems do not exist in isolation. Many of them reflect problems in the larger health system. Some of the elements which prevail in that system are:

- National health care spending has been steadily rising in the last two decades to a point where it now accounts for 10 percent of the GNP. Much of the recent increase is attributed to unprecedented medical inflation rates.

- Health care expenditures affect the national economy. Rising health care costs increase the cost of other goods and services. For example, the rising cost of insuring against health care expenses affects not only individuals, but also the price of their labor. Employers must pay higher premiums for workers' health insurance. They in turn pass their increased expenses onto the consumers of the goods and services they sell.

- An increasingly larger proportion of national resources is devoted to health care at the expense of other goods and services.

  The consequent problem in an inflation plagued industry such as health care becomes not necessarily the proportion of dollars spent, but on how well the money is spent. Therefore, we must ask: Is the increasing amount of GNP spent on medical care buying a comparable amount of improved care, or are we just spending more for the same product?

- Rising health care and related costs encourage inappropriate and frequently counter productive responses to save money. These range from individuals' avoidance of necessary care due to the cost and reduction in employer paid health insurance coverage.

Both sets of problems, those of Medicare and those of the larger health system, must be solved. A strategy, however successful, applied just to the Medicare program will solve neither set. It could affect Medicare by netting some short-term budgetary savings, but the problem of rising costs will not disappear. It will resurface elsewhere in the system. And health care costs will continue to escalate.

Evidence abounds to substantiate the need for deliberate, system-wide reform to control Medicare and other health care expenditures. Medical inflation continues to outpace that of the general economy. Attempts by the Reagan Administration to modify that trend have failed. They have been off-target and designed only to reduce federal spending. What they have accomplished, however, is the imposition of unreasonable financial burdens on the elderly and the encouragement of providers' to continue their cost-increasing and cost-shifting behaviors.

The President's FY 1984 proposals continue this failed strategy to a shocking degree. Never before have effects on the elderly of both the Administration's misguided budget policies and the uncontrolled hospital inflation been more apparent. Hospital costs are rising, but the FY 1984 budget would impose co-payments on the beneficiary. These are some examples of the Medicare proposals:

- In spite of unprecedented hospital inflation rates, and the fact that beneficiaries' current out-of-pocket expenditures as a proportion of income nearly equal those of pre-Medicare levels, the Administration would require the elderly to pay far more for hospital care. A ten-day hospital stay which now costs $304 would cost the elderly patient $630 next year. That is more than one and a half times greater than the average monthly Social Security benefit! ($375 per month for a widow and $406 per month for a retired worker)
- Physician reimbursement levels would be frozen at current levels. The problem of physicians refusing to take Medicare assignment and thus charging patients fees exceeding allowable levels is related to the already inadequate Medicare fee schedules. Such a proposal will exacerbate the problem and force the elderly to pay even more for physician care.
- The Part B deductible and premiums would increase. These steps would pass greater proportions of program costs onto the beneficiaries and further erode their financial access to care.

These proposals would not generate true cost-savings but cost-shifting. They and others, such as vouchers, delayed eligibility, and the prospect of catastrophic coverage, are thinly veiled attempts to reduce Federal responsibility and commitments regardless of the disproportionate burdens such steps will place on the elderly and the private sector health consumers, insurors, and providers. Such unconscionable recommendations clearly illustrate how urgent the need is for health system cost-saving strategies.

What strategies would produce the savings which are so desperately needed but which have thus far eluded us? One promising plan is to implement a prospective payment system. The National Council of Senior Citizens has long advocated such a system as an effective means of cost control because it encourages cost consciousness and economic efficiency among health care providers and places the providers, not the patients, at risk. Until providers become financially accountable for their decisions, we believe that this country will not begin to control health care costs.

The National Council of Senior Citizens, therefore, views a prospective payment system covering all insurors and all providers as an essential element of a system-wide cost control policy. We believe that prospective payment should be applied toward the entire health care system. The resultant savings would benefit all purchasers of health care, including the Federal government and the Medicare beneficiaries.

Until a system-wide prospective plan is adopted, we believe that the Administration's recommendation of a Medicare prospective payment plan for hospitals could be a step in the right direction. However, since such a plan could merely shift more of the government's cost to other purchasers of hospital services and yield no system-wide savings or efficiency, we caution you to consider this plan very thoroughly.

Our major concern is the anticipated impact that the Diagnostic Related Groupings System (DRG) will have on the Medicare beneficiary. I will now discuss some of these concerns. In theory the DRG plan has many attractions. It would reimburse hospitals according to complexity of cases rather than the length of hospitalization and intensity of services used by each patient. Thus it would attempt to streamline hospitals' costs by offering monetary incentives for limiting resource use to only that which is appropriate and necessary for each DRG. The standard cost would be a pre-determined rate for each diagnostic related grouping.

We believe that the immediate beneficiary of a DRG plan would be the Federal government. Ultimately the older person should benefit because the government should be able to use its limited Medicare resources more efficiently. However, we also believe that there is a danger that the government would be the only beneficiary of the savings. If that should happen, or if the wrong provider incentives are encouraged by DRGs, the elderly Medicare beneficiary will be harmed, whether or not additional cost-sharing is prohibited.

During your deliberations you undoubtedly will hear of the ways that DRGs are expected to save Medicare dollars, to promote hospital efficiency, and to allow for predictability of expenditures. These are desirable goals and we urge you to adopt a system that will achieve them. However, we also urge you never to lose touch with one element that can be lost as DRG advocates try to impress you with terms like "ease of administration," "quick implementation," predictable payment," "prudent buyer," and "reduced administrative burden." The element that can not be omitted is *the "patient"*.

I will now cite some possible situations in which NCSC believes the beneficiary could be harmed under a DRG system if hospitals do not respond as the Administration predicts:

- *Medicare admissions could be discouraged, thus denying access to older patients*. Such discrimination could be subtle but effective. For example, Medicare patients in need of non-emergency or elective procedures could be placed on waiting lists while patients with private insurance coverage are readily admitted. A similar practice might be employed to admit those elderly whose cases do not appear complicated (or who might be more "profitable") over those who do.

- *Some admissions could be encouraged whether or not the hospital is the most appropriate site for treatment*. Older people are at very high risk of complications when hospitalized. If a hospital deems it more profitable to admit certain cases now treated on an out-patient basis, the Medicare patient will be exposed unnecessarily to further illness. In addition, Medicare costs will increase.

- *The use of ancillary services could be restricted, reducing the hospitals cost per case but denying patients the services which adequately promote or enhance recovery*. The amount of physical therapy administered, for example, could determine the functional level of an older person at discharge and the need for post-hospital care.

- *Conversely the use of ancillary contracted services which could be shifted out of DRG payment schemes and into Part B reimbursement could be encouraged*. HHS may prohibit paying twice for a service (under A and B), but charging under Part B will *increase* the patient's financial responsibility because of the co-payment requirement and the assignment problem.

- The quality of care administered could be seriously impaired. For example, a hospital may opt for reducing its costs by cutting back on staff qualifications and training, patient to staff ratios (including professional and non-professional levels), purchase of new technology, and upkeep of equipment, to cite just a few undesirable cost-cutting techniques. The Administration's recent move to relax regulations governing hospitals participating in Medicare could exacerbate the problem.

- The length of hospital stay could be inappropriately shortened, seriously affecting the Medicare patient's discharge status. For example, for many older people, one or two days added to or cut out of a hospital stay could mean the difference between going to a nursing home after discharge or going to one's own home. Cutting a hospital stay too short may save the hospital money but, when shortened inappropriately, it can add to Medicare's after hospital costs, and threaten the patient's recovery.

Can these situations occur? We believe they can, although we feel that most hospitals will strive to avoid such practices. However, some may do so unwittingly if reimbursement levels are too low or arbitrarily applied to DRGs. Others, motivated more by profit than by dedication to good patient care, may do so deliberately. We hope such practices do not occur, but we are not convinced that the necessary safeguards will exist to either monitor or discourage such behavior.

The National Council of Senior Citizens sees many other potential problems with a Medicare only, hospital only prospective payment system. To illustrate these problems, I will pose a series of questions. (The assumption I am making is that such a system will be based on the HHS, DRG model, but most of these questions should be asked of any prospective system.)

- Can a prospective payment system be applied only to Medicare without causing "savings" to become costs for other insurors as well as the whole health care system?

- If the system does not produce the predicted Federal savings and provider efficiency, will the beneficiary be taxed with additional cost-sharing to compensate for its failure?

- Can the elderly patient with multiple diagnoses, chronic illness, and debility fit neatly into a DRG category? How will complications which occur after admission be considered under the DRG scheme? Will the DRG adequately compensate the hospital for these problems?

- Will hospitals or physicians manipulate diagnoses or patient descriptors to slip a case into a similar category with a higher reimbursement level? (DRG creep)

- Will the reimbursement levels reflect true per case costs or merely the government's desired spending targets? Will the "prospective" part of DRGs just apply to the Federal government's benefit? That is, will the government set its budget and then set DRG rates to fit that budget?

- How will hospital administrators, trying to cut costs per case, affect physicians' admissions practices and utilization of hospital services? Will the physician have any incentive to reduce hospital costs? Will the physician gain if he/she helps to reduce costs per case?

- Will physicians treat more cases in their offices, at greater expense to the beneficiary (since reimbursement for physician care requires a patient co-payment) and at possible risk to the patient where out-of-hospital care is inappropriate?

- How will hospitals with currently high Medicare and Medicaid populations or legitimately high costs be able to operate under a DRG prospective system? Will some have to close, cutting off access to the beneficiary? (Particularly vulnerable are the inner city and rural hospitals.)

- Since the plan will squeeze only Medicare reimbursement, what costs will be shifted to other insurors and non-Medicare patients to compensate for the limitation of Medicare reimbursement?

- Can we expect a parallel effort by private insurors to institute prospective reimbursement to avoid cost shifting without firm Federal commitment to encourage such a response?

- Will hospitals be reimbursed for uncompensated care, or will such costs be shifted to non-Medicare payors?

- Will states be allowed flexibility to operate current or developing cost-control plans?
- Will Health Maintenance Organizations, proven systems of efficiency and cost-savings, be treated separately to prevent their costs from increasing as they have under the New Jersey plan?

The basic concept of prospective payment is a good one, and such a plan could be successful if these problems are addressed. However, at a time when reimbursement reform is needed to make the whole health system economically efficient, DRGs should be considered only a first step. It is a step that needs to be taken, but one that Congress should not implement without improving the plan and looking toward applying reimbursement reform system-wide.

The National Council of Senior Citizens believes that, to solve some of the problems I have mentioned, flexibility should be built into the DRG system's design and implementation. In addition, steps should be taken to further assure beneficiary protections.

We believe that to mandate a prospective payment plan based on only one, nationally applied model, such as would be required by the Administration's proposal, would penalize many states and preclude the flexibility they need to achieve effective cost containment. For example, during the past several years, mandatory hospital cost containment programs have been adopted in Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington, and Wisconsin. All of these states provide convincing evidence that prospective budgeting and payment lead to savings in total hospital costs and in cost per admission compared to the present cost reimbursement method. These programs have similar goals, but an essential element is different: Each state's program is tailored to meet the needs of that state.

A mandated national DRG plan could prevent some states from maintaining a program that has worked successfully and which, in many cases, is applied to all payors. In some cases it would require that a uniform program be modified for one payor: Medicare.

NCSC believes that implementation of a prospective payment system which allows the states some flexibility without compromising DRGs' goal is possible. Perhaps the DRG plan could be used as a baseline model. As long as a state's plan generates savings equal to or greater than those anticipated from DRGs, the state plan should be allowed to continue. Thus the goals of economic efficiency and predictable budgets would be preserved.

The National Council of Senior Citizens is particularly concerned about treatment of the Medicare beneficiary under a DRG plan. The Department of HHS has responded to fears of system abuse, DRG creep, and handling of outliers by promising monitoring of admissions, verification of DRGs, and adjustments in payments. HHS has also assured that assignment will be mandatory, and that additional cost-sharing by the beneficiaries will be prohibited. Such steps are necessary and could be effective in certain cases, given adequate HCFA staffing and effective state monitoring activities. In addition, they may prevail only as long as the system does not break down.

We are also concerned about the problems which may never be exposed to monitoring. For example, a beneficiary who experiences subtle discrimination by a hospital, perhaps through a queuing technique, or a beneficiary who receives inappropriate out-of-hospital care will not be considered by a utilization review committee or a monitoring of hospital admissions. Yet these beneficiaries could be harmed as much as those who suffer from such DRG system abuse as unnecessary surgery.

Mr. Chairman, the NCSC believes that in spite of the urgent, widely recognized need for reimbursement reform, the DRG plan should not be rushed through the Congressional process. It requires very careful examination of how the plan will affect all involved groups, consideration of alternative measures, and determination of what the plan will actually accomplish.

We urge you to devote adequate time to take these necessary steps. It is true that we cannot afford to let hospital inflation continue. However, we also cannot afford hastily to impose a national, largely untested plan that will affect the operation of this nation's hospitals and the health of its vulnerable citizens. Quick implementation can lead to long-term damage that could be harder to reverse than it would be to solve the current problems.

We believe that the DRG plan must be considered not only thoroughly, but also separately. To rush it through as part of the fiscal year 1984 budget would preclude the scrutiny it requires, and could lead to its failure. The budget process, therefore, is not the proper vehicle for this plan. We understand that the Reagan Administration would like to see DRGs in place by October 1, 1983. However, such hasty implementation could only result in ill-advised short-term budgetary savings at the expense of some hospitals and their Medicare patients.

Mr. CLAYMAN. One fact that's clear—and I have been learning from just sitting here for a short time; indeed, I may have suspected it before—that medicare is indeed a complicated issue. There are no ready and easy answers. And, therefore, we must not act in haste.

The modest success of the Social Security Reform Commission, in agreeing on a package, must not lull us into a euphoric mood that we can find quick answers to satisfactory cost containment in the medicare field. But there are some hard economic facts that we believe we can all agree upon. Hospital care costs have accelerated at a jet speed. While CPI in 1982 was 3.9 percent, hospital care cost was up to 12.6 percent. Medicare spends nearly 75 percent of its resources for hospital care, thus subjecting three-quarters of the total expenditures to the highest patient rate in our economy. In spite of medicare, which we all greeted as a great release and comfort for the aged, the aged now spends substantially the same percentage of their income on health care as they did before medicare came into being. This unhappy reality flies in the face of the administration's proposal to add more costs to be thrust upon ailing oldsters.

For example, a hospital stay of 11 days, which now cost the beneficiary $304, would cost under the proposed plan of the administration $630. Now that is inflation at its rampaging worst. This is not in our judgment worthy cost savings. It is an attempt to achieve, in our judgment, short-term budget reductions at the expense of the elderly's financial and health status. This proposal, as we see it, would hold at ransome the health and lives of the elderly to cut the budget regardless of the consequence. What we need instead is a strategy which assures sound medical care without financial hardship. So, the question is, what strategy would provide savings without deterioration of care or financial burden to the patient?

One promising plan is to implement a prospective payment system. The National Council of Senior Citizens has long advocated such a system because it encourages cost consciousness and economic efficiency among health care providers, and places the providers, not the patients, at risk. We believe that until such a plan is adopted for all payors and all providers, the administration's recommendation of the medicare prospective payment plan for hospitals could be a step in the right direction. However, since such a plan would merely shift more of the Government's cost to other purchasers of hospital services and yield no system wide savings or efficiency, we caution you—although I suspect you need not be so cautioned by me—to consider this plan very thoroughly.

Our major concern is the anticipated impact of the administration's recommended diagnostic related grouping system will have on medicare beneficiaries.

Some of our concerns are medicare admissions could be discouraged conceivably, thus denying access to older patients. Some admissions could be encouraged whether or not the hospital is the most appropriate site for treatment. The use of ancillary services could be restricted, reducing the hospital's cost per case, but denying patients the services which adequately promote or enhance recovery. The quality of care administered could be seriously impaired. The length of hospital stay could be inappropriate, shortened, seriously affecting the medicare patient's discharge status.

Let me quickly close if you will give me another 30 seconds.

Senator DURENBERGER. I will give you 45 because you will probably take it anyway. But go right ahead.

Mr. CLAYMAN. All right. [Laughter.]

Now, let me conclude this very hastily. And that took 10 seconds.

We have been hearing that perhaps the Congress may be considering—some in Congress may be considering rushing through the idea that has been expressed by some in Congress as a part of a social security reform package. While our organization has cited after deep thought and grieving over the problem not to fight the package if other parts are added to it. If a whole coterie of issues are associated with it, I simply suggest that it is entirely conceivable that the whole package may unravel. And we urge that this not be part of the political strategy that is adopted by this subcommittee or by the leadership of the Senate or the House; whichever party is immaterial.

Having said that and having taken too much time, I thank you for being gentle with me.

Senator DURENBERGER. Well, I am glad we gave you the 45 seconds and you only took 30 of it to say that, because if you ask the chairman of this subcommittee or the chairman of this committee, they would both be pleased to hear what you have just said about the social security bill. I trust that you can take that same message to others right now on perhaps the other side of the Hill. And I do appreciate your comments here this afternoon and your effort to put this material together.

I think we have one more witness, James M. Hacking, assistant legislative counsel, American Association of Retired Persons, Washington, D.C.

Mr. CHRISTY. Mr. Hacking had to leave.

Senator DURENBERGER. Right. I saw Jim leave about a half hour ago.

STATEMENT OF JACK CHRISTY, ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, D.C.

Mr. CHRISTY. Yes. He has multiple responsibilities today, so he has delegated this one to me. And it is my pleasure to be here.

I won't go over the litany of statistics that already document the increase in hospital costs in this country. I am sure you are well aware of this and the whole committee is. I would like to point out, however, that the uncontrolled increase in hospital costs has had a profound impact on the hospital insurance trust fund of medicare. So, the point, as you know, is that the fund is going to be insolvent sometime this decade. So, that bringing hospital costs under control is one of the highest priorities of AARP.

We have outlined in our testimony that we basically support the prospective pricing system, as I guess is what it amounts to, but as we approach the problem there are several elements that we think should be part of the package specifications. On the last two pages of our testimony we summarize what those specifications are.

The first one is coverage. We believe the system should cover all payors, all services and all hospitals because of the cost shifting problem. We do believe if there are any exemptions from coverage they should be based on impacts to the system. If there is not exemptions and the system would have a higher cost in general without the exemptions, then exemptions could be considered.

For the basis of payment in the DRG, in the prospective payment system, we support the DRG concept. We think it adds lots of possibilities for improving the way hospitals are reimbursed and introduces all kinds of new incentives for changing the relationships between hospital administrators and doctors which would have a positive cost saving impact on the system.

We think that the DRG system, however, is inadequate for reimbursing innercity and teaching hospitals. So, we would urge that the Congress consider applying on top of the DRG system some sort of severity of illness index so that those hospitals can be compensated for their demonstrably more critical cases.

We support the concept of basing the DRG on a national average, adjusted for local wage levels. We think that is good idea. We think that that will put doctors and hospitals around the country more at risk for the type of care they give. And we think that that will have a good effect on cost.

We think that the DRG system as proposed by the administration omits capital funding and teaching hospitals from the reimbursement mechanism. We think it is incumbent upon the Congress to raise those issues and have wide ranging debates on the question of whether the third party reimbursement system is the proper mechanism for addressing those issues at all. And we suspect that when we come to capital funding, uncompensated care in teaching hospitals, that rationally different funding mechanisms would apply to each. But it is important that we start that discussion and get it moving quickly because the funding problem, in particular, is going to go a long way in deciding where hospitals will be built, which hospitals will be refurbished, how care will be delivered, and who gets care. So we would urge that hearings begin on that immediately. We recognize that they are omitted for reasons of complexity at this point in the discussion, and we understand that. But we would like to see some movement on that at the very earliest time.

We also believe that leaving the future adjustments of the DRG rates up to the sole discretion of the Secretary is not in the best interest of the system, and that some mechanism should be devised that would include proper input from interested consumers, maybe a formula of some type decided beforehand so that those rate adjustments and a schedule for reviewing timely rate adjustments could be on the table beforehand.

Assignments mandatory for all hospitals and all physicians employed or contracting with hospitals. And we would go further that there should be some kind of incentives developed as part of the system to try and bring more providers into accepting assignments. We think that utilization review is absolutely critical for any prospective reimbursement system, and that the utilization review mechanism should have consumer representation and very strong enforcement powers.

Our two last points go to the implementation of the system. We don't think that States should be forced into a single prospective reimbursement plan. Within broad guidelines specified by HHS, we believe that States should be permitted to develop alternative plans as long as the savings projected are equal to or greater than what would be under the Federal plan.

And, finally, we hope that the prospective reimbursement system won't be rushed along on a fast track, whether it is an independent fast track or the 1984 budget process track. We think that when you are changing the payment mechanism of medicare it deserves long and careful consideration, and that the fast track and the chaotic nature of a fast track doesn't lead to that kind of consideration.

[The prepared statement of Mr. Christy follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

Introduction

The American Association of Retired Persons is pleased to state for this subcommittee its view of the prospective payment concept in general and the diagnostic related groupings (DRG) methodology in particular. AARP has long supported and urged Congress to design and implement a prospective payment methodology to control health care costs. We welcome the development of this dynamic reimbursement concept as an essential step toward stabilizing hospital costs.

Context of the Problem

Health care costs in general and hospital costs in particular have continued to escalate at unacceptable rates despite the sharp decline in inflation in all other sectors of the economy. Thus, though the Consumer Price Index for 1982, increased at an annual rate of 3.9 percent, hospital costs soared at nearly 14 percent.

The result of runaway inflation in the health sector of the economy has been runaway inflation in the Medicare Program. Medicare expenditures have increased by an average of 18 percent per year for the last five years. Since 75 percent of all Medicare expenditures are for hospital care, soaring hospital costs mean there will be no relief in Medicare expenditures soon.

The growth in Medicare expenditures has had a profound impact on the Hospital Insurance (HI) Trust Fund. Recent legislative changes bringing federal employees into the Medicare Program have given the HI Trust Fund a few additional years of solvency. Nevertheless, HCFA projects the fund will not have enough funds on hand to meet its obligations by some time this decade. And unlike the Old Age and Survivors Trust Fund, the deterioration in the HI Trust Fund will not be reversed by the more favorable economic and demographic conditions expected to prevail in the 1990's. Congress and the American people are facing the erosion of the nation's commitment to health care for the elderly and disabled. Coming to grips with that reality and sustaining the commitment to accessible, affordable health care for the aged and disabled is the explosive dilemma resulting from uncontrolled hospital inflation.

The essential prerequisite to addressing the near term Hospital Insurance Trust Fund financing problem is the stabilization of hospital costs. Without stable hospital costs nothing is possible: Medicare and Medicaid expenditures will continue to escalate beyond reason; employers will pay higher and higher health insurance premiums which further lessen their ability to employ new workers because of rapidly increasing payroll taxes; the HI Trust Fund will continue to deteriorate, and all health care consumers, including the elderly, will pay higher out-of-pocket costs for health care.

The Prospective Payment Concept

The American Association of Retired Persons believes that prospective payment can help stabilize the uncontrolled growth in hospital costs. Prospective payment (PP) introduces three new incentives for hospitals to control costs: (1) hospitals are motivated to anticipate and justify future expenditures and to establish the need for new facilities and services in attempting to gain recognition of the costs of their plans in their prospective rates; (2) hospitals are motivated to identify and monitor the cost implications of the quantity, quality and scope of services they provide to operate within their rates; and (3) hospitals are motivated to keep their actual costs below their rates to avoid losses and achieve surpluses. This could lead to more effective and efficient operations.

AARP believes that a hospital, by containing its costs, can earn a surplus sufficient to maintain its viability while receiving less revenue than it otherwise would receive under current reimbursement methods. This belief, central to the PP concept, is the basis for our support and optimism about the efficacy of prospective payment.

Essential Elements of a Prospective Payment Plan

There are over thirty prospective payment plans in operation around the country; some are run by State agencies, some by Blue Cross plans, some by hospital associations and some by private insurers. Though important substantive differences occur as a result of how a plan establishes the amount of its prospective payment (i.e., by rate commission, mathematical formula, face to face negotiation, etc.), the extent to which hospitals, services and payors are covered by the plan as well as the basis of payment (i.e., per discharge, per diem, per diagnostic related group (DRG) are, in general, more important indicators of a plan's chances to control spiraling health care costs, than are the structure and methods of the cost controlling administration.

A. Coverage

Coverage describes the extent to which major elements of the health care delivery system are under the jurisdiction of the prospective payment system. Generally speaking, the greater the coverage the greater the chances that the system can control costs. HCFA sponsored research shows that the extent to which a prospective reimbursement system covers payors (Medicare, Medicaid, Blue Cross/Blue Shield, private insurers, etc.), services (Part A/Part B inpatient/outpatient), and hospitals (any exemptions from coverage) will, usually to a like extent, determine the ability of the prospective system to control cost.

(1) Payors

The more payors covered by a prospective payment program, the lower the ability of the hospital to circumvent revenue controls for some payors by raising prices charged to other, noncovered payors.

Congress's mandate to HHS was to develop legislative proposals which provide that hospitals, skilled nursing facilities (SNF) and, to the extent feasible, other providers would be paid under Medicare on a prospective basis.

This mandate is insufficient because it limits the prospective payment system to Medicare. A Medicare specific payment system makes it very difficult, if not impossible, to control health care inflation because of cost shifting.

The process by which hospitals cover discounts given certain types of payors, such as Medicare and the Blues, by assessing those discounts against other payors, usually private insurance companies, is called cost shifting. According to the Health Insurance Association of America (HIAA), 16 percent of the hospital expenses paid by private insurance is for discounts taken by Medicare and Medicaid patients. Cost shifting has increased so much that health insurance premium payors can no longer absorb the increase in premium rates necessary to finance the shift. All three categories of witnesses (HIAA, Blues and GHAA), at a recent Senate Health Subcommittee hearing on Medicare reimbursement, agreed that Congress must create a "level playing field" so that all payors for health care services are treated fairly. As long as hospitals can continue to shift costs, they will have no incentive to be more efficient.

(2) Services

Though the Congressional mandate speaks to "hospitals, SNFs and, to the extent feasible, other providers", it is important that all services -- Medicare Parts A and B, inpatient and outpatient services -- be covered under the prospective payment plan. In the absence of such coverage, there is the real possibility that a change of services from Part A to Part B, or from inpatient to outpatient, will result in additional payments without any reduction in payments under Part A.

For example, if a hospital leases its radiology department to a physician, that service will stop being Part A and become a Part B service. Under a prospective payment system, the hospital would receive the prospective payment for the inpatient services. In addition, however, the now Part B x-rays will cost the system an amount in excess of the prospective limit, thus undercutting the purpose and savings of the prospective payment plan. Similarly, if outpatient services are not covered under the prospective payment plan, hospitals could collect the prospective payment for inpatient services and then transfer the patient to outpatient status where additional revenues could be exacted.

(3) Hospitals

Any exemption for hospitals from the prospective payment system must be carefully considered, especially within the context of the proposed plan because of the potential for cost shifting through patient shifting. Cost shifting through patient shifting occurs when some hospitals within a local hospital market are exempted from participation in the prospective payment program, but others are not.

For example, under the first AHA plan, small hospitals (100 beds or less) had the option of participating under the plan or not. Because that plan's payment methodology provided for discharge-based payments, determined by inflating full historical costs per discharge, a small hospital opting into the prospective system would receive full inflated costs for every discharge in the budget year. If the discharges were drawn from a neighboring small hospital (same number of beds) which opted to remain on cost-based reimbursement, the latter hospital would lose no revenue unless they reflected their volume reduction in lower costs. The potential for cost shifting through patient shifting makes it important to require that participation options be uniformly exercised within local hospital markets.

B. Basis of Payment

The basis on which a prospective payment plan establishes the amount of payment has an important influence on the incentives created by the program. For example, programs that limit the total revenues of a hospital, rather than establish per diem or per case rates, create less incentive for hospitals to circumvent the system by increasing admissions and length of stay. Programs limiting total revenues, however, must closely monitor hospital revenues for compliance. The looser the monitoring, the longer the lag between receipts and compliance, the more difficult it is to control hospital costs. Programs that set payment rates, on the other hand, affect a hospital's cash flow immediately and, therefore, affect costs immediately.

There are a number of methods by which to determine the basis of payment in a prospective payment system. The simplest methods to administer, establishing the payment on a per admission, per diem or per discharge basis, create strong incentives to either increase hospital admissions, extend hospital stays or skim the healthy patients who are less expensive to treat while avoiding the more costly ones.

A variation of the per admission method that reduces incentives to skim healthy patients adjusts the payment per admission for differences in overall patient case mix. The Department of Health and Human Services (DHHS) favors a case mix approach -- diagnostic related groups (DRGs) -- for determining the basis of payment in the HCFA prospective payment plan.

In the Department's DRG system, patients are grouped by major diagnostic categories. These are further divided by five variables that explain, with an acceptable degree of accuracy, variations in resource consumption as measured by length of stay for different illnesses. This procedure results in 467 diagnostic related groups (DRGs).

The hospital is paid on a per case basis with the amount of payment based on rates calculated for each DRG. If a hospital spends more than its DRG rate for a specific diagnosis, it loses money. If it is able to treat the patient for less, the hospital keeps the savings.

DRGs offer several important advantages. In addition to neutralizing perverse incentives inherent in other prospective payment methods, the number of DRGs is manageable, the groups are medically related and statistically similar, and the information required to administer the system provides a significant management tool.

DRGs do, however, have problems too. Perhaps the most troublesome problem from a cost savings point of view is DRG creep. DRG creep occurs when providers "game" the system by fudging a diagnosis in order to get a patient into a higher paying DRG category. Similarly, DRGs could encourage unnecessary surgery because payment for the same diagnosis is higher when surgery is involved. The elderly already have surgery at a higher rate (165 surgeries/1000 population) than the under age 65 population (92 surgeries/1000 population). It is essential that any prospective payment system have a strong utilization review program to address these problems.

DRG critics also object to tying diagnoses to payment rates because it could interfere with the development of new, more effective technologies. Methods of evaluating innovations could be developed, however, so that new technologies could be incorporated into the DRG payment system. However, interference with the automatic implementation of new technology could be considered a benefit of the DRG system.

New technology is a powerful force driving up hospital costs. Though health planning and the certificate of need process has forced significant savings by disapproving unnecessary purchases of new technologies, the health care system has yet to develop an adequate method of evaluating the cost of new technology relative to its benefits. The systematic evaluation of new technology to be incorporated into the DRG payment system could be an effective method of relating benefits (of innovation) to costs. Such systematic scrutiny of new technology could contribute to the quality of care and the ultimate cost of care.

DRGs appear to present a particular problem for health maintenance organizations (HMOs). Some argue that per case reimbursement, based on average length of stay, neturalizes and even reverses the traditional HMO incentive to reduce length of stay. Why should HMOs encourage hospital stays below the average for a specific diagnosis if the HMO must pay on the basis of the average? Development of the DRG based prospective payment system must not be permitted to undermine the savings potential of HMOs. The Department's solution, offering HMOs the option of being paid on a per capita basis, as current law allows, or receiving the same DRG based prospective rates as hospitals, seems adequate under current circumstances; HMOs have a small market share and the prospective proposal is Medicare specific. Nevertheless, HMOs in the DRG system should continue to be studied and monitored so that one cost containing system does not disadvantage another.

The most decisive determinant of the efficacy of DRG reimbursement is the payment formula. DRGs are intended to be length of stay homogeneous groups which take into account five variables: the patient's age, the presence or absence of a secondary diagnosis and the presence or absence of surgery. Relying on length of stay, the patient's age and the other variables, however, does not produce a sufficiently sensitive surrogate for resource consumption to differentiate patients' burdens of illness.

A funadamental requirement for conrol of inpatient hospital costs is a means of classifying patients by a standard that accurately reflects a patient's use of health care resources. AARP believes that the DRG payment formula must take into account severity of illness to effectively match reimbursements to patient mix. Otherwise, urban public hospitals, those hospitals with the sickest patients and most expensive mix of cases, will not be adequately compensated under a DRG based system.

AARP supports DHHS's decision to base the DRG payment formula on national averages, adjusted for wage levels in various parts of the country. We believe that tying the DRG payment formula too closely to local norms may perpetuate utilization patterns in much the same way that PSRO norms did for length of stay. For example, HCFA has reported to Congress wide variations in hospital utilization among regions of the country. In the Northeast, for example, in 1979, total days of hospital care per thousand for Medicare patients was 4,124 days. In contrast, the West had only 2,752 days. These differences are not accounted for by age, sex, race or case-mix standardization. They are historically consistent and apply to the under 65 population as well.

Some believe that the large number of HMOs in the West account for part of the difference. Most believe, however, that the variance is caused by physician practice patterns -- a complex set of beliefs, attitudes and practices -- common to the region. If doctors on the East coast discharged patients like doctors on the West coast, Medicare would save an estimated $10 billion a year. Differing physician practices, having no basis in medical necessity, are detrimental to Medicare and Medicare beneficiaries. By making physican practice norms roughly uniform for all regions, it puts hospitals and physicians at risk for the services they provide.

AARP believes that DHHS's proposal to leave future DRG rate adjustments solely to the discretion of the Secretary will unnecessarily politicize the Medicare payment mechanism. AARP supports a fixed DRG rate review schedule and a specific formula for adjusting the rates from time to time. The formula should consider evaluations of past performance for each DRG, as well as consideration of future developments impacting DRG rates. The review and adjustment process must solicit and consider the views of Medicare recipients and accord the appropriate Committees of the Congress at least a 30 day review and approval responsibility for changes in DRG rates.

Three additional areas traditionally dependent upon the reimbursement mechanism for financing must be considered, directly or indirectly, in the new payment scheme. Whether or not the three areas -- allowances for teaching hospitals, uncompensated care and capital funds -- should be financed through the third party reimbursement system is a policy question that deserves wide-ranging debate. The Department has chosen to exclude capital and medical education costs from the DRG rate calculation and reimburse for them separately. AARP recognizes the complexity of the issues involved and understands the desire to move the prospective payment system as quickly as possible without additional complications. Nevertheless, the importance of capital and medical education costs to the health care system can no longer be ignored. AARP urges Congess to initiate a wide-ranging debate on these issues at the earliest possible time. The most appropriate financing mechanism for medical education, uncompensated care and capital will probably be different for each activity. These activities are fundamental, however, to our health care system; how they are financed will have a major influence on who gets care and how and where it is delivered. Serious consideration of these issues can no longer be postponed.

Finally, DRGs only apply to hospital inpatients. An outpatient DRG system must be developed if the system is to fully realize its potential for savings.

C. Assignment

Under current law, assignment (accepting what Medicare pays as payment in full) is mandatory under Part A and optional, at the discretion of the physician on a case by case basis, under Part B. Moreover, many people wonder why Medicare contracts with hospitals that do not require hospital based physicians to accept universal assignment.

After a Medicare patient has surgery, the hospital bill goes to the Part A intermediary and the surgeon's bill goes to the Part B carrier. Under current law, there is no check on whether the surgery billed was actually performed or was as complex as indicated in the hospital record. Though the Association approaches the issue of universal assignment with an open mind, merging Part A and Part B services -- at least in the inpatient context -- seems to offer both financial and administrative advantages.

AARP is aware of the special interests advocating that hospitals be permitted to choose, like physicians, whether or not to accept assignment. Any Medicare hospital payment proposal that would permit hospitals to bill beneficiaries for any sum beyond the appropriate DRG rate would contribute to cost inflation and be unacceptable to AARP. Furthermore, any prospective payment plan that requires greater direct out-of-pocket expenditures for Medicare participants than does the current law is not acceptable to AARP.

D. Utilization Review

HCFA studies show that programs imposing utilization penalties on hospitals are likely to curtail revenues more than programs that do not impose such controls. Utilization review is, therefore, an essential tool for controlling costs no matter what type of prospective reimbursement system finally emerges.

Whether the basis of payment is per diem, per discharge, or per DRGs, if left uncontrolled, health care providers will "game" the system to increase reimbursements. To minimize "gaming" and thereby more effectively control costs, the prospective payment plan must have a strong commitment to utilization review. An adequate utilization review mechanism would include beneficiary representation, full access to pertinent information, very narrow, if any limitations on disseminating information, and an effective enforcement capability.

AARP agrees with former Secretary Schweiker that utilization review is crucial for a successful prospective payment system. We question the Administration's commitment to DRG based prospective payment while totally phasing out PSROs. We urge Congress to provide adequate funding, consumer representation and meaningful enforcement capabilities so that Professional Review Organizations (PROs) can fill the necessary void created by the demise of PSROs.

E. Federal Pre-emption

AARP has long supported a prospective reimbursement approach to contain hospital costs. Beyond that broad notion, however, the Association believes it is essential that states, within general guidelines, have the flexibility to implement the prospective payment concept as they see fit. Each state is unique. What works in New Jersey may not work in California. AARP opposes restricting states to a single prospective payment methodology.

Within broad guidelines and uniform reporting requirements specified by HHS, states should have the flexibility to develop their own prospective payment plan as long as the savings projected are equal to or greater than the savings under the federal plan.

F. Prospective Reimbursement and the Legislative Process

Hospital reimbursement is the heart of the Medicare Program. Like open heart surgery, change in Medicare reimbursement is a complicated and delicate operation. Like heart surgery, the stakes are the life or death of the national commitment to high quality, accessible, affordable health care for the elderly and disabled.

AARP believes that the seriousness and scope of this undertaking require the most deliberate legislative consideration. We urge Congress to proceed with the development of prospective payment separately from consideration of the FY 84 budget or any other "fast track" legislation. The harried and chaotic nature of the fast track, like the budget process, does not lend itself to the in-depth scrutiny and deliberation required to change the Medicare reimbursement system.

Though we recognize and are sympathetic to industry's desire for the stability that prospective pricing promises, a complete overhaul of the mechanism by which the federal government will spend $44.7 billion in FY 84 deserves careful and deliberate consideration. Moreover, the recent extension of section 223 limits to ancillary hospital costs deserves a chance to become effective. Putting prospective payment legislation on the "fast track" would not allow sufficient time to develop adequate information about the operation of the new 223 limits.

Summary of Recommendations

The following specifications outline the basic criteria AARP considers important in evaluating a prospective reimbursement plan. Recognizing that runaway costs in the health care sector, particularly hospital costs, is the engine powering the drive to a prospective payment system, health care cost containment and quality care must be the major goals of the new system. The specifications outlined below are committed to those goals. Moreover, they address critical financing problems for inner-city and teaching hospitals, yet allow states the flexibility to achieve health care sector savings under their own prospective payment plan.

1. Coverage. The system should cover all payors, all services and all hospitals. Otherwise, there will be cost shifting.

   Exemptions from coverage should be allowed when coverage results in higher costs to the system.

2. Basis of Payment. The basis of payment that offers the best chance for developing a meaningful pricing mechanism is diagnostic related groupings (DRGs). It is essential that the payment formula include a severity of illness index, provisions for teaching hospitals, uncompensated care and capital funding. The DRG rates should be reviewed periodically and adjusted according to a pre-established formula.
3. Assignment. Mandatory for hospitals and for physicians employed or contracting with hospitals. Development of stronger incentives to encourage other health care providers to accept assignment.
4. Utilization Review. There must be a strong utilization review capability that includes adequate consumer representation and enforcement powers.
5. States should not be forced into a single prospective reimbursement plan. Within broad guidelines specified by HHS, states should be permitted to develop alternative plans as long as the savings projected are equal to or greater than the savings under the federal plan.
6. Prospective payment legislation should not be put on a fast track or developed as part of the FY 84 budget process.

Senator **Durenberger**. All right. Thank you very much. Let me just say that this is not the first day that we have addressed this issue of a fast track. I don't know how long we have to await around here these days to change things, but when something is broken I would like to see it fixed as soon as possible. So I don't consider us on a fast track. I understand what you said though. It relates to what Mr. Clayman said earlier about don't tack it on to something you know is going to slide through because it has to slide through. Consider it on its merits. And I think that is a fair comment. We should not make the HI trust fund hostage to social security. We are making it look like it is shaky and, therefore, we are coming along with quick solutions to fix it up because the system looks shaky. And it isn't. There has been a lot of money in that system.

What you said about teaching hospitals and capital issues are deep concerns to everybody on this committee, and as soon as we have time we will start the hearing process on all of those issues. It was all right in the old days to lay the cost of teaching and research on sick people, but today it is just much too difficult for a sick person, and particularly the elderly, to carry all of the cost of hundred thousand dollar liver transplants and medical education and everything else.

So I hope you go out of here thinking positively about prospective pricing and the DRG system. I assume your support for it reflects all your payers concern that you don't want the cost of elderly health care in America fostered on the young. I don't think we are shifting the cost of retired persons' health care to the employed people. We are trying to strike a balance that I don't think has existed in the past.

So I appreciate very much the thoughtfulness of all of these statements and in particular the concern that you have expressed in your representative capacities for some 29 million people.

Senator Long, do you have any comments or questions?

Senator **Long**. No, I do not.

Senator **Durenberger**. I thank you very much for your testimony. If there is one question that I might ask each of you to react to it is about the potential problems that could arise from early discharges or inappropriate admissions. Do you have feelings about the role of peer review in making sure that any system like this works well? Do any of the three of you want to comment on that?

Mr. **Clayman**. If it works at all, there has to be some oversight features obviously, because we are dealing with a large industry involving great sums of money, and we are dealing with clientele that isn't aware. The average aged person knows nothing about the hospital except as they are there. They make none of the decisions, absolutely none. They are told when to go to the hospital, when to get out, what kind of treatment, what to eat. And none of the decisions are made by them. So they are, if I may use the word, utterly ignorant. And so somebody who has the trust of essentially the people, the patient populations, has to have a very tight and serious oversight authority. If you were to ask me exactly what that should be, I would have to claim ignorance, too.

Senator **Durenberger**. I appreciate that. Any other comments?

Mr. **Christy**. I would like to say a kind word for peer review organizations. I think they have the kind of enforcement mechanisms that are necessary to make the peer review responsibility operate effectively. And we would like to see them go forward.

Senator **Durenberger**. Thank you very much. We appreciate your testimony.

Our final witness this afternoon will be Mr. Cooper Parker, president-elect of the American Health Planning Association, and director of the Office for Health Planning and Intergovernmental Relations, Iowa State Department of Health, on behalf of the American Health Planning Association.

Senator **Long**. Mr. Chairman, before we hear from this witness I might just ask the Chair whether we are going to hear a statement by the American Federation of Labor? I have a statement before me here that was prepared, I see, for Mr. Robert McGlotten, legislative representative, Department of Legislation, American Federation of Labor. Is that gentleman or anybody from that organization going to be here?

Senator **Durenberger**. No. I was just handed a note here earlier that Bob was not going to be able to be here and that they were going to have to stand on their written testimony. So apparently they have not been able to testify this afternoon.

Senator **Long**. Well might I say I find that unfortunate. It would seem to me that the witness would be well advised to be here if he could, or send someone. But I think it is a useful statement, and I think that, given the significance of this matter for the rank and file of American workers, it would have been appropriate for someone from the AFL-CIO to have been here to explain the point of view of their organization. I think they have an interesting statement, but I believe it would have attracted more attention if there had been a witness up here.

Senator **Durenberger**. I cannot disagree with your observation.

Senator **Long**. Thank you.

Senator **Durenberger**. Mr. Parker and colleagues.

STATEMENT OF COOPER PARKER, PRESIDENT-ELECT, AMERICAN HEALTH PLANNING ASSOCIATION, WASHINGTON, D.C., ACCOMPANIED BY STANLEY J. MATEK, AND JIM O'DONNELL, DIRECTOR OF GOVERNMENT POLICY

Mr. **Parker**. Thank you, Mr. Chairman. For the record, I don't want to mislead the Senate. At the time this testimony was prepared I was the deputy commissioner of health for the State Department of Health in Iowa. The day before yesterday I resigned that position to take another position, but I am here today representing the American Health Planning Association. I just wanted to introduce that for the record.

I am accompanied today before you by Stanley J. Matek, who is the executive director of the Health Planning Council of Orange County and a member of our Board, and by Jim O'Donnell, who is the director of government policy for our association. And with your permission, Mr. Chairman, I will speak briefly for 4 or 5 minutes and then Mr. Matek will make a brief statement for the remainder of the time.

Senator DURENBERGER. That is fine. And your printed statements will be made part of the record.

Mr. PARKER. Thank you. We appreciate the opportunity that you have given us to provide our views on prospective payment systems and on the administration's proposal in particular. Our association studied this issue and the outlines of the administration's proposal at our December board meeting and we adopted the following statement of our position.

No. 1, capital expenditures should be explicitly included in designing payment systems. No. 2, the administration's prospective payment proposal, which contains a capital passthrough, would stimulate unnecessary capital expenditures and defeat the cost containment objective of the proposal. AHPA cautions against the development of payment systems which provide incentives to encourage capital expansion without demonstrated need. And we are prepared to work with the administration and other interested groups to devise solutions to this critical issue.

We support efforts to restrain health care costs, which are now escalating at three times the national rate of inflation, and we support the development of new payment systems designed to inhibit rising health care costs. But we object to the notion that prospective payment systems alone, particularly prospective payment systems which address only operating costs, can accomplish what needs to be done.

We have some reservations about some of the assumptions, the implications and the specifics of the administration's proposals. They are as follows. Although the proposal concedes that prospective payment systems alone cannot do the complete job, it then rejects any attempt to link prospective payment systems with systems for restraining capital expenditures. We have learned in health planning that capital expenditure review programs and prospective payment systems are most effective when they are linked together to form a combined strategy for addressing both operating and capital costs. As long as capital expenditures are passed through, there is the potential for the pass through becoming a flood. There are three areas of concern that we have about the proposed pass through.

No. 1, passing through capital costs will continue to inflate hospital costs because the new capital expenditures will result in increased supply and utilization. The prospective payment system limits operating costs per case. Yet capital passthrough allows for increasing the supply in order to treat more cases.

No. 2, as long as a prospective payment system is geared to medicare only, the increased operating costs, as you have heard elsewhere today, will be passed on to other payors. And it doesn't make much sense to us to pay for a building but not for the cost to provide service within the building. It would be more effective, in our judgment, to allow for those capital expenditures and their associated increases in operating costs which have been approved under a capital expenditure review program.

The administration's proposal not only allows for the unrestrained flow through of capital costs, it in fact stimulates an already expensive component of health care cost escalation by encouraging hospitals to make new capital expenditures as quickly as possible. The proposal is quite clear in stating that capital costs will eventually be included in prospective rates. Combined with the current past through, this is an open invitation to invest now and build up a base of reimbursable debt before limits are place on capital costs.

Finally, we believe that there are legitimate needs for capital expenditures. But we believe that they must not be paid for unless they have been carefully reviewed by State and local communities to determine the need for and the affordability of the proposed expenditures.

We strongly recommend to you and to your colleagues in the Senate that any prospective payment system you enact should contain recognition of the cost implications of the capital expenditures pass through and that you require that capital expenditures be reviewed by a State capital expenditure review program in order to be reimbursable, by whatever method. It is interesting to us to note that the demonstration States cited in the administration's proposal as having restrained costs while operating prospective payment systems are among the leaders in linking prospective payment systems with capital expenditure review programs. We concur with the testimony you have heard from New York State that clearly supports the continuing need for a health planning program as a necessary component of an effective system for restraining costs.

In conclusion, we support the efforts of the Federal Government to develop payment systems which provide incentives for cost containment. However, such systems, in our judgment, must be developed in conjunction with programs which address the supply side of the equation. Thank you.

[The prepared statement of Mr. Parker follows:]

TESTIMONY OF THE AMERICAN HEALTH PLANNING ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH,
SENATE FINANCE COMMITTEE

February 17, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE.

My name is Cooper Parker. I am President-Elect of the American Health Planning Association and Director of the Office for Health Planning and Intergovernmental Relations, Iowa State Department of Health. I am accompanied today by Stanley J. Matek, Executive Director of the Health Planning Council of Orange County and a member of our Board. I am here today representing the state and local health planning community, which is committed to assuring access for all Americans to quality care at a reasonable cost.

We appreciate the opportunity you have given us to provide our views on prospective payment systems and on the Administration's proposal.

The Association supports the development of an effective, equitable and workable payment system. We studied this issue and the outlines of the Administration proposal at our December board meeting and adopted the following statement of our position:

- Capital expenditures should be explicitly included in designing payment systems.

- The Administration's prospective payment proposal, which contains a capital pass-through, would stimulate unnecessary capital expenditures and defeat the cost containment objective of the proposal.

- AHPA opposes the development of payment systems which have incentives encouraging capital expansion without demonstrated need.

- AHPA is prepared to work with the Administration and other interested groups to devise solutions to this most critical issue.

In other words, we support efforts to restrain health care costs, which are now escalating at three times the National rate of inflation. We support the development of new payment systems designed to inhibit rising health care costs. But we object to the notion that prospective payment systems alone, particularly prospective payment systems which only address operating costs, can accomplish what needs to be done.

We have serious reservations about some of the assumptions, implications and specifics of the Administration's proposal. They are:

- Although the proposal concedes that prospective payment systems alone cannot do the complete job (that the health care industry is too complex to respond to one solution), it then rejects any attempt to link prospective payment systems with systems for restraining capital expenditures. We've learned in health planning that capital expenditure review programs and prospective payment systems are most effective when linked together to form a combined strategy for addressing both operating and capital costs.

- As long as capital expenditures are passed through, there is the potential for the "pass through" becoming a flood. There are three areas of concern about the proposed pass through:

    1. passing through capital costs will continue to inflate hospital costs because the new capital expenditures will result in increased supply and utilization. The prospective payment system limits operating costs *per case*,

yet capital pass through allows for increasing the supply in order to treat more cases. Simply put, if a hospital adds ten beds and fills those beds, it increase the number of cases, thus the limits per case will not be effective in restraining overall costs.

2. As long as a prospective payment system is Medicare only, the increased operating costs resulting from a capital expenditure will be shifted on to other payers.

3. You have already received testimony from hospitals requesting that "certain major operating cost increases associated with new capital be recognized" outside the prospective per case limits. This is recognition of the fact that a one dollar investment in capital generates approximately a 30¢ increase per annum in operating costs. It doesn't make much sense to pay

for a building but not for costs to provide service within the building. It would be more effective to allow for those capital expenditures and their associated increases in operating costs which have been approved under a capital expenditure review program.

- The Administration's proposal not only allows for the unrestrained flow through of capital costs, it in fact stimulates an already expensive component of health care cost escalation by encouraging hospitals to make new capital expenditures as quickly as possible. The proposal is quite clear in stating that capital costs will eventually be included in prospective rates. Combined with the current pass through, that is an open invitation to invest now and build up a base of reimbursable debt before limits are placed on capital costs. In addition, it assumes that an equitable and workable formula can be developed for building capital costs into a prospective rate. We do not believe the Department has the capacity for that now, nor will it in the near future. We note that the states which have developed prospective payment systems have not been able to develop an equitable prospective rate for capital costs.

- Finally, we believe that there are legitimate needs for capital expenditures. We also believe, however, that a system which passes through new costs without checks and balances will pay for unneeded capital growth in the future. At a time in our Nation when funds are scarce and in an industry that is volatile in its inflationary spiral, new capital expenditures must not be paid for unless they have been carefully reviewed by state and local communities to determine the need for and affordability of the proposed expenditures.

We strongly recommend to you and to your colleagues in the Senate that any prospective payment system you enact should contain recognition of the cost implications of the capital expenditures pass through and that you require that capital expenditures be reviewed by a state capital expenditure review program in order to be reimburseable, by whatever method. It is interesting that the demonstration states cited in the Administration's proposal as having restrained costs while operating prospective payment systems are among the leaders in linking prospective payment system with capital expenditure review programs. We concur with the testimony you have heard from New York State that clearly supports the continuing need for a health planning program as a necessary component of an effective system for restraining costs.

As you know, the Administration's FY 84 budget again calls for the elimination of any Federal funding for the health planning program, despite clear Congressional action to maintain the program. We thank the Congress for its wisdom in its unwillingness to abandon all restraints on capital expenditures and urge you to continue to do so. We believe you can do this by requiring that the costs of any future capital expenditures in a prospective payment system only be allowable if approved through a capital expenditure review program, and by continuing to urge your colleagues in the Senate to reauthorize an effective health planning program.

We recognize that the current health planning program needs to be streamlined and stand willing to work with you and the Administration to do so. We do not, however, believe elimination of capital expenditures reviews is prudent. Moreover, it would serve to increase both the supply and utilization of beds for which prospective payment will be made and thus self-defeating.

In conclusion, we support the efforts of the Federal government to develop payment systems which provide incentives for cost containment. However, such systems must be developed in conjunction with programs which address the supply side of the equation.

Thank you for providing us this opportunity to present our views.

Senator **Durenberger**. Thank you.

Mr. Matek. Mr. Chairman, I would like to just underscore the points made by Mr. Cooper Parker from the context of a local health planning agency and what we are seeing happening down there. We think the DRG proposal is basically good, but we want to emphasize that a capital passthrough would intensify a building boom which already is occurring. We have seen in the last 18 months a quadrupling of our local certificate of need notices of intent. And I would like to submit for the record an article that appeared in last Sunday's New York Times, headed "Hospitals engaged in building boom," which gives you a quick sample survey from various States in the Union as to just how much capital expansion proposal is increasing nationwide.

Senator **Durenberger**. I think I have already made that part of the record.

Mr. **Matek**. Oh, great. All right. That building boom is part of a struggle for a market position which is intensifying the pressure that hospital administrators are feeling to give into demands for expansion now, and an automatic capital passthrough would simply guarantee them the ability to lay claim to financing in the money markets support that kind of a thing.

Second, we are observing a distortion of systems structure at the local level, and specifically a shift of power in the financial markets, in the bonding markets, in the money markets, toward the national chains and away from independent, nonprofit institutions. I am a little surprised that some of those institutions haven't come forth to point this out. But we are seeing a definite shift in ownership, and, therefore, a shift in service patterns in the kinds of hospital services that are being made available or that are being promoted or that are being marketed in the system. That weakening of the nonprofit institutional status is something that I think is going to take a little more examination before we let something as apparently subtle as an automatic capital passthrough further shift the market viability of various institutions in our health care system. That has not been well examined.

Third, I believe that the capital passthrough without a review mechanism attached to it is an open invitation to yet heavier debt financing systemwide. And I am not sure that we want to make that kind of a commitment. It is going to imprison us later when we might want to shift capital to other sectors of the health care system and to create incentives for other kinds of services.

The industry in this country, the hospital industry, is now in a state of turmoil. And I believe until we understand a little bit more about the effects of the incentives we offer, we ought to at least keep accountability mechanisms in place. And I believe the automatic capital passthrough would destroy what little accountability we now have for the use of capital in this industry and for its operating cost consequences. Therefore, I plead with you not to keep that automatic passthrough as part of the DRG proposal. I would propose instead that you use the review mechanism and the approval mechanism to selectively strengthen institutional positions in the money market based on appropriateness, not simply based on ready access capital and the ability to get into the market first.

We would propose that instead of abandoning certificate of need review and health planning that you streamline and improve those programs. And we will be ready in the American Health Planning Association to offer four pages worth of specific proposals for the record on how that can be done. And we would urge that in moving cautiously toward a DRG program that will really work you assure data and review systems that will enable you and us to keep on top of things like DRG creep and other kinds of frankly inevitable beat the system efforts.

And with that we would like to thank you for the opportunity to make these points.

Senator DURENBERGER. Thank you. Are you going to make a comment or respond to questions?

Mr. O'DONNELL. No.

Senator DURENBERGER. Thank you.

I am just going to start with a couple of observations and see whether Senator Long has any. I have asked myself those same kinds of questions during the course of the last 6 or 9 months that we have been looking at the process. We had Governor Keene over at the Environment and Public Works Committee a couple of weeks ago, and he was bragging about his AAA bond rating. I congratulated him on having a AAA bond rating. My State is slipping down, and I don't know whether it is B now or something like that, but it is not doing very well.

But I said, I notice that everyone of your hospitals is getting a AAA rating, and they go out and get more money. And it seems to me that is because Wall Street doesn't really quite understand what Willis Goldbeck was telling us here a little while ago about how we are going to be buying health care. Now, the way Wall Street looks at the system, they look at Maryland or New Jersey and they see a rate fixing operation going on. They have got an all payor system, and they set this deal up with all the hospitals and there is a guaranteed return, using the DRG system to do it. And so if you look short term at it, I can understand why they got a AAA rating. If you look behind that at what some New Jersey employers and the employers around the country are doing with PPO's and some of these sort of things, you see that there is something else evolving in this country besides a semiregulated approach to the purchase of hospital care.

And I think what this committee has been trying to do over the last few years, from the time I came on when the Senator from Louisiana was the chairman of the committee, is to send out signals that there is change taking place. We don't know exactly the form that change is going to take. We don't know exactly what our role is. But it is going to come. I mean it is just as clear as if you can count numbers; you know it is coming. And I would hope that sufficient signals are out there to the hospital industry in America, although the New York Times' article would not indicate that is the case. But, in part, it might be an assumption that in going to DRG's we might be just furthering this sort of regulated process in a different fashion.

I know you are in the certificate-of-need business, and I think you know I don't like certificate of need very much. It is just another form of regulation. Well, actually it is a form of franchising.

I mean, every time you say no to somebody, you are franchising in somebody who is already there. It is a regulated process that people can count on.

But if you have some specific suggestions for us on how we can deal with this capital issue, other than just factoring it into the DRG, and other than just holding hearings on it, I think we would be very receptive. But I know the administration has looked at that issue and tried to figure out how best to work it in, and just came to the conclusion that it is, in the short term, a very, very difficult issue and hard to come to grips with. The best thing that we can do in the short term is to let as many people as possible know that at some fixed point in time we are going to be dealing with this issue conclusively.

Mr. **Parker**. Well, the States have had the same difficulty. And we note that they haven't gotten any further along toward a solution than the Federal Government has. And we think that probably the Bureau is not prepared at this point to come up with an equitable formula either.

Senator **Durenberger**. Let me ask you a different kind of question, which is, what do you see going on out there that is different and beneficial to all of us in community wide or statewide health planning? Last year we heard from Rochester, N.Y., for example, about the innovative approach to community-wide health planning. They just went out and did it.

Is there much of that type of health planning starting to develop in this country?

Mr. **Parker**. I think what we are seeing from our vantage point is the increased participation, active participation, of business and labor coalitions around the country. They have had their interest and they have been there for some time. But they have now learned about the planning process and they are very eager to get involved with that because it ties them into information which they as purchasers need to have in order to make prudent decisions. It also gets them involved with PSRO. It enables them to be more effective than they have been in the past. And their participation enables health planning to be more effective than it has been in the past.

In Iowa recently the former Governor appointed a commission on health care costs which consisted of representatives from business, labor, and major purchasers. And one of the first things that they determined in looking at the information needs that are there and that are unmet, and, second, the scope of the problem, the first recommendation they made to the Governor was that he continue the certificate of need program because it was the only mechanism in effect in the State which gave them any handle at all on capital expansion.

Mr. **Matek**. One interesting thing that has come up in our area lately is the Securities and Exchange Commission has invited us to comment on new corporation stock proposals that are going to be put on the market. And we recently wrote them a four-page memo on one new company that is developing in our area a way that we think we can bring data and information about system behavior to bear upon the private market.

I would like to emphasize, however, that Willis Goldbeck made a critical point when he talked about the need for data. So if we don't like regulation in health care, there is really only one alternative, since we don't have price benefit competition, and that is going to be good accountability. If we have adequate information that we can offer to perspective buyers, you don't have to have a regulation because then they will know how to behave in their best self-interest.

Right now, a certificate of need is necessary because we don't have enough information in the relationship between cost and prices and productivity. And the chief advantage of the certificate of need is not the review process but the people that go through it. The chief advantage is the people that keeps out of the game; 60 percent of our effectiveness in that program is the sentinel effect, the people we discourage before they ever bring that application in the door.

Senator DURENBERGER. I don't consider that necessarily a bad idea. If somebody can come in and take care of the Gray Panthers and AARP and all the rest of these people for a lot less than the existing system, I want to see some way for them to get in.

Mr. MATEK. So do we.

Senator DURENBERGER. And the certificate of need does not provide it at least in the traditional way.

Mr. MATEK. Well, no, I would disagree with that. I think it not only provides it, but we go out there and help them. And we have recently in the last 4 or 5 years produced more than 20 skilled nursing facility applications where we went out and invited them, and then helped them write them, and helped get them through. Now, of course, we filled up that unmet need, and so now it is going to be the other way.

Senator DURENBERGER. How do you do with things like freestanding surgical centers?

Mr. MATEK. Well, right now if you apply for a surgical center in a hospital, or if it is designated as a freestanding surgical center it has to be reviewed and, therefore, comes under this quota problem we have got; whereas, if you open it as a private physician's office, it is not reviewable. That is right now in California the hottest issue of conflict.

My personal opinion is that we could afford to not review freestanding surgical centers, provided that people knew who was running them, what was being done in them, what was being charged, and, of course, what the morbidity outcome was.

Mr. PARKER. And if that kind of information were readily available to the major purchasers there would be no need for certificate of need to determine whether or not you could have a freestanding surgical center. But that information is not available right now.

Senator DURENBERGER. Thank you all very much. We appreciate your being here from all over the country, and we appreciate all of your testimony. To the best I can tell, unless we ran out of paper, that is it. I thank you all very much for being part of this hearing.

[Whereupon, at 3:24 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

Testimony for

AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE

The American Association of Foundations for Medical Care (AAFMC) is the only national association which represents Individual Practice Associations (IPAs), IPA-type Health Maintenance Organizations (HMOs) and Foundations for Medical Care (FMCs).

Since its founding in 1971, AAFMC has been in the forefront of the fast growing HMO community promoting the development of IPA-type HMOs and programs aimed at assessing the quality and appropriateness of health care services.

The history of AAFMC is highlighted by the pioneering work done by the early FMCs. Begun in 1953, these forerunners of today's IPAs are successful and growing.

AAFMC member plans offer programs of comprehensive benefits that stress quality of care. AAFMC and its members work with industry, labor and insurance companies in developing and offering comprehensive health programs that emphasize quality assurance and cost effectiveness through sophisticated utilization review programs. They represent health programs that are cost effective by building around existing facilities and services.

AAFMC's 1981 membership included 109 plans representing 31,010 participating physicians and a combined enrollment of approximately 2,243,000.

Association membership continues a steady growth as the popularity of Individual Practice Associations and Foundations for Medical Care increases.

Members of AAFMC participate in a wide range of activities and educational programs.

AAFMC policy is established by a House of Delegates and a Board of Directors elected by the House of Delegates.

AAFMC maintains the International Institute for Health Care Alternatives, a non-profit organization established to provide consultative services and technical assistance to organizations and governments within the United States and in other parts of the world.

We appreciate this opportunity to comment on the DRG-based hospital reimbursement system which the Department of Health and Human services has proposed to the Congress.

HMOs are vitally interested in this proposal since its inappropriate application to HMOs could deprive our members of their competitive advantage in the marketplace, particularly under the revised system of Medicare reimbursement for HMOs in risk contracts which this Committee approved as part of the Tax Equity and Fiscal Responsibility Act last year. These changed provisions have much encouraged our members to bring the advantages of their operation to Medicare patients. The major theory under these changes is that HMOs can save money for the government and still provide additional services to Medicare beneficiaries through their unique efficiencies in providing health care.

One of the principal ways in which our members perform more efficiently than the health system outside HMOs is our ability to make special arrangements with hospitals on the rates to be paid but, more importantly, to restrain unneeded hospital admissions, lengths of stay and in-hospital services.

HMOs would lose these advantages if they were required to pay hospitals on a DRG basis. If an HMO paid a hospital on a DRG basis where the lengths of stay are, in effect, averaged, it would be paying the hospital more than its fair share if HMO admissions were, on average, less costly within each DRG than the general health delivery system in an area. For example, if an HMO were able to get their surgical patients out of the hospital a day earlier than for similar patients outside HMOs, it would be the hospital, not the HMO, which would gain.

It is for this reason that we were pleased to see recognition of this problem in the Department's report to Congress on DRG. On page 57 of the report is the following statement:

Health maintenance organizations provide hospital and other services to approximately 10 percent of the population including nearly 3 percent of the Medicare population on a pre-paid capitated basis. Therefore, HMOs have a strong interest in keeping people well and out of the hospital.

Section 114 of TEFRA allows payment to be made on behalf of Medicare beneficiaries on a per capita basis for those HMOs under a risk sharing contract. The statute requires the per capita rate to be 95 percent of the expected cost in the current fee for services system, and many believe that the majority of HMOs will enter such agreements. PPS will not change this arrangement for HMOs which choose risk sharing contracts. However, the statute also allows HMOs to be paid on a reasonable cost basis. In PPS, the Department believes that these HMOs should be paid the same prospective rate as would be paid to other hospitals. Thus, the non-risk sharing HMO would be paid what otherwise would have been paid to any hospital.

We urge the Committee to give risk-taking HMOs complete freedom to make their own reimbursement arrangements with hospitals or to use the Medicare system, as recommended by HHS. While cost-reimbursed HMOs should generally follow the usual Medicare policies for paying hospitals, as also recommended by the Department, we see no reason to prohibit a cost-reimbursed HMO from using another method if costs to Medicare would be lower.

We appreciate this opportunity to make our views known to the Committee by inclusion of our statement in the record of hearings.

AMERICAN FOUNDATION FOR THE BLIND, INC.

1660 L STREET, N.W.
WASHINGTON, D.C. 20036
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STATEMENT OF
THE AMERICAN FOUNDATION FOR THE BLIND

BY

GLENN M. PLUNKETT
SPECIALIST IN GOVERNMENTAL RELATIONS

TO THE

SENATE FINANCE COMMITTEE
ON A
HOSPITAL PROSPECTIVE PAYMENT SYSTEM
FOR THE MEDICARE PROGRAM

FEBRUARY 22, 1983

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I APPRECIATE THE OPPORTUNITY TO SUBMIT THE FOLLOWING STATEMENT FOR THE AMERICAN FOUNDATION FOR THE BLIND. THE FOUNDATION IS A NON-PROFIT VOLUNTARY RESEARCH AND CONSULTANT ORGANIZATION IN THE FIELD OF SERVICES TO BLIND PERSONS OF ALL AGES.

IN PRESENTING OUR VIEWS ON THE PROSPECTIVE PAYMENT SYSTEM, WE EXPRESS OUR CONCERNS NOT ONLY FOR THOSE WHO ARE BLIND OR VISUALLY IMPAIRED BUT

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FOR ALL MEDICARE ELIGIBLES SINCE THE MEDICARE PROGRAM IS THE MAJOR HEALTH CARE PROGRAM FOR THE AGED, BLIND AND DISABLED WHO ARE ELIGIBLE FOR SOCIAL SECURITY BENEFITS. OUR CONCERN IS THAT WHATEVER PAYMENT SYSTEM OR SYSTEMS ARE INSTALLED, ACCESS TO HEALTH CARE FOR THE AGED, DISABLED AND BLIND NOT BE CURTAILED.

WE ARE COGNIZANT OF THE RISING COSTS OF HEALTH CARE. UNFORTUNATELY ALL THE OTHER COSTS THAT THE POPULATION AT RISK MUST BEAR CONTINUE TO RISE AS WELL; LEAVING LESS AND LESS TO OBTAIN HEALTH CARE AT A TIME IN LIFE WHEN THE NEED IS GREATEST. AS YOU RECOGNIZE, ALL EFFORTS TO DATE TO RESTRAIN THE COST OF HEALTH CARE HAS BEEN AT THE BURDEN OF THOSE IN NEED. FOR EXAMPLE, DEDUCTIBLES AND COPAYMENTS HAVE INCREASED AND THE PART B PREMIUM HAS RISEN. ALONG WITH HOSPITAL AND NURSING HOME COSTS THE MEDICARE ELIGIBLE MUST PAY, PHYSICIANS HAVE INCREASED CHARGES AND AS A HIGH PERCENTAGE OF PHYSICIANS DO NOT ACCEPT ASSIGNMENT, THE USERS BEAR A GREATER AND GREATER SHARE OF PAYMENT FOR MEDICAL SERVICES. ALL OF THOSE HIGH COST SERVICES STILL DO NOT INCLUDE THE OUT OF HOSPITAL AND OUT OF NURSING HOME PRESCRIPTION DRUGS WHICH ARE NOT COVERED IN ANY WAY BY MEDICARE. THE COST OF DRUGS WILL BECOME A GREATER AND GREATER COST BURDEN FOR THE AGED, BLIND AND DISABLED AS THEY ATTEMPT TO AVOID THE HIGHER COST (TO THEM) OF HOSPITALIZATION BY SELF MAINTENANCE AS LONG AS POSSIBLE. NATURALLY, SUCH EFFORTS MAY LEAD TO HIGHER COST HOSPITAL SERVICE AT A LATER DATE WHEN THE INDIVIDUAL'S CONDITION HAS DETERIORATED SO THAT MORE INTENSIVE CARE, WITH COSTLY TECHNOLOGY, MUST BE USED TO SAVE HIM OR HER.

ACTUALLY, THESE ARE NOT PROBLEMS WHICH THE AGED, BLIND AND DISABLED FACE ALONE; THEY ARE PROBLEMS THAT WE ALL FACE. WE ARE CAUGHT UP IN A

WEB OF INCREASING NEEDS, IMPROVED TECHNOLOGIES, PRESUMABLY AN EXCESS OF MEDICAL DOCTORS, AN ADEQUATE NUMBER OF HOSPITAL BEDS IN MOST GEOGRAPHIC AREAS, AND INCREASING COSTS TO THE CONSUMER AS IF THE DEMAND EXCEEDED SUPPLY. HOWEVER, THE ONLY PROPOSED ALTERNATIVES ARE THOSE THAT ATTEMPT TO RESTRAIN COSTS BY REDUCING AVAILABLE SERVICES AND BY SHIFTING MORE AND MORE OF THE COST TO THE CONSUMER IN ORDER TO LESSEN DEMAND.

A PROSPECTIVE PAYMENT SYSTEM, ESPECIALLY ONE BASED UPON DIAGNOSES GROUPINGS WOULD DO NOTHING TO ALLEVIATE THE PROBLEM FOR THE CONSUMER OF HEALTH SERVICES. IT WOULD NOT MAKE MORE SERVICES AVAILABLE, IT WOULD NOT ENCOURAGE ALTERNATIVE SERVICES AND IN ALL LIKELIHOOD WOULD MAKE SERVICES FOR MANY TYPES OF ILLNESSES, INJURIES AND DISEASES MORE DIFFICULT TO COME BY ON A TIMELY BASIS. REGARDLESS OF CASE MIX, RATE SETTING, CAPS ON EXPENDITURES BY TYPES OF SERVICES OR FOR CERTAIN COST CENTERS, THE NET EFFECT IS ON THE INDIVIDUAL IN NEED OF SERVICE. THE SERVICE PROVIDER, WHETHER THE INDIVIDUAL PRACTICIONER, HOSPITAL OR NURSING FACILITY IS GOING TO ADJUST ITS PRACTICES AND SERVICES TO MAXIMIZE ITS RETURNS TO ATTAIN ITS ACTUAL OR PERCEIVED ECONOMIC GOALS.

EFFORTS TO RESTRAIN RISING COSTS THROUGH VARIOUS METHODS ARE IN EFFECT IN SEVENTEEN STATES; SOME OF THOSE HAVE BEEN IN EFFECT SINCE 1969. THE RESULTS OF THOSE EFFORTS ARE MIXED AT THE BEST AND THEIR EFFECTS ON COSTS AND HEALTH SERVICES ARE DIFFICULT TO ASSESS TO ANY GERAT DEGREE OF SPECIFICITY. SOME OF THE DIFFICULTIES IN ASSESSING THE RESULTS OF COST CONTAINMENT ARE RELATED TO THE GEOGRAPHIC LOCATION OF PROVIDERS OF SERVICES, SIZE AND TYPE OF POPULATION AT RISK, THE RELATIVE MIX OF INCOME GROUPS, ATTITUDES OF USERS AND PERCEPTION OF MEDICAL PROFESSIONALS WHO REFER PATIENTS TO PROVIDERS AS WELL AS AVAILABILITY OF PROFESSIONALS IN THE PROVIDERS' FACILITIES.

I RESPECTFULLY REFER YOU TO THE HEALTH CARE FINANCING REVIEW OF DECEMBER 1982 (VOL. 4, NO. 2). THAT REPORT INCLUDES RESEARCH ARTICLES ON SUCH STUDIES AS "THE EFFECTS OF HOSPITAL RATE SETTING PROGRAMS ON VOLUMES OF HOSPITAL SERVICES", "THE EFFECTS OF PROSPECTIVE REIMBURSEMENT PROGRAMS ON HOSPITAL ADOPTION AND SERVICE SHARING", "HOSPITAL PAYROLL COSTS, PRODUCTIVITY, AND EMPLOYMENT UNDER PROSPECTIVE REIMBURSEMENT; AMONG OTHERS. THE REPORTS AND CONCLUSIONS FROM THE STUDIES LEAVE THE SIGNIFICANT QUESTIONS AS TO OVERALL EFFECTS ON COSTS, POPULATION AT RISK AND PROVIDERS OF SERVICES UNANSWERED, BUT A GENERAL CONCLUSION CAN BE DRAWN FROM THE REPORT THAT THE COST CONTAINMENT FACTORS AS MEASURED DID NOT IMPROVE SERVICES OR NECESSARILY REDUCE PROGRAM COSTS. FOR INSTANCE, THE CONCLUSION ON HOSPITAL PAYROLL COSTS, PRODUCTIVITY, AND EMPLOYMENT UNDER PROSPECTIVE REIMBURSEMENT CONTAINS THE FOLLOWING: "RESULTS OF TESTS ON THE PAYROLL PER DAY AND FTE PER DAY HYPOTHISES SUPPORT THE ARGUMENT THAT, UNDER PR HOSPITALS CUT PAYROLL COSTS AND CREATE PRODUCTIVITY. HOWEVER, PRICE AND SKILL-MIX HYPOTHISES, TESTED--SHOW FEW STATISTICALLY SIGNIFICANT PR EFFECTS AND GREAT INCONSISTENCY IN THE SIZE AND DIRECTION (THAT IS, POSITIVE VERSUS NEGATIVE) OF THESE EFFECTS. HOSPITALS ARE SUBJECT TO AREA WAGE MOVEMENTS, WHICH ARE LIKELY TO BE INFLUENCES AS MUCH BY LABOR SUPPLY FORCE AS BY PR COST-CUTTING INFLUENCES ON HOSPITAL LABOR DEMAND." THE REPORT FURTHER STATES THAT "WE NOTED EARLIER THE ARGUMENT THAT APPARENT CHANGES IN "PRODUCTIVITY" MAY BE DUE TO ALTERATIONS IN THE AMOUNT AND QUALITY OF SERVICES PROVIDED. OTHER PRELIMINARY NHRS FINDINGS SUGGEST THAT HOSPITALS MAY RESPOND TO PR FY ALTERING VOLUME AND SERVICE PROVISION. ACCORDING TO WORTHINGTON (1980), MARYLAND AND NEW YORK SHOWED SIGNIFICANT INCREASES IN OCCUPANCY

RATES AND AVERAGE INPATIENT LENGTH OF STAYS THAT WERE ASSOCIATED WITH PR. BOTH FINDINGS ARE CONSISTENT WITH DECREASED TOTAL AND PAYROLL COSTS PER DAY -- ONE CAN ARGUE THAT RETARDED SERVICE ADOPTION IS CONSISTENT WITH COST CONTAINMENT, AND MIGHT BE ASSOCIATED WITH FTE STAFF REDUCTIONS". QUOTING FROM THE ECONOMETRIC RESULTS SHOWN IN THE STUDY "THE EFFECTS OF HOSPITAL RATE-SETTING PROGRAMS ON VOLUME HOSPITAL SERVICES: A PRELIMINARY ANALYSIS", A SIMILAR CONCLUSION IS DRAWN AS THAT SHOWN ABOVE, I.E. "RATE-SETTING PROGRAMS ARE MOST LIKELY TO AFFECT HOSPITALIZATION IN TWO WAYS: 1) BY INCREASING THE LEVEL OF UTILIZATION, AND 2) BY INFLUENCING THE ANNUAL RATE OF CHANGE IN SERVICE USE. LIGHTER BUDGET CONSTRAINTS IMPOSED BY RATE-SETTING PROGRAMS THAT TIE HOSPITAL REVENUE TO UNITS OF SERVICE MAY GIVE HOSPITALS AN INCENTIVE TO INCREASE THE NUMBER OF UNITS PROVIDED. THIS MAY TAKE THE FORM OF LONGER STAYS OR THE ADMISSION OF MORE PATIENTS. AS A RESULT OF THESE ACTIVITIES, THE DOWNWARD TRENDS IN HOSPITAL USE DESCRIBED EARLIER MAY DECELERATE, IF NOT REVERSE".

OUR FEARS ARE THAT, REGARDLESS OF THE CASE MIX, RATE SETTING, CAPS ON EXPENDITURES OR WHATEVER THE COMBINATION OF COST CONTAINMENT FEATURES THAT MIGHT BE ADOPTED, THE AGED, DISABLED AND THE BLIND WILL BE ADVERSELY AFFECTED. WE SEE THE EFFECTS OF COST CONTAINMENT PROPOSALS AS REDUCTIONS IN ACCESS TO HEALTH SERVICES BY THOSE MOST IN NEED. WE CAN SEE THAT PROVIDERS WILL AVAIL THEMSELVES OF THE MOST BENEFICIAL (TO THEM) CASE MIX BY ACCEPTING HIGHER PAYING DIAGNOSES, BY MOVING THE LOWER PAYMENT DIAGNOSES OUT QUICKLY AND MAINTAINING A HIGHER BED POPULATION OF HIGHER PAY PATIENTS, I.E. HEART ATTACKS, CANCER AND OTHER DIFFICULT CASES NEEDING MORE COSTLY TEHCNOLOGY. OVER THE LONG RUN, ESPECIALLY IN HEAVILY POPULATED URBAN AREAS, WE MAY SEE HOSPITALS DEVOTED SOLELY TO TREATMENT OF HIGHER REIMBURSEMENT PATIENTS WHILE THOSE WITH LOWER REIMBURSEMENT DIAGNOSES ARE SHIFTED TO HOSPITALS THAT WOULD HANDLE LOWER REIMBURSEMENT

LEVEL PATIENTS. WHERE SUCH SERVICES ARE IN PLENTIFUL SUPPLY AND THE MEDICAL CARE IS AS GOOD AS IN THE HIGHER REIMBURSEMENT HOSPITAL, SUCH MIGHT NOT BE A DISSERVICE. HOWEVER, NOT ALL GEOGRAPHIC AREAS WOULD HAVE SUFFICIENT FACILITIES TO ACCOMODE A SHIFT IN BED POPULATIONS AND THE LOWER LEVEL REIMBURSEMENT PATIENT MAY HAVE TO WAIT LONGER AND LONGER FOR CARE. AGAIN, THE PROVIDERS MAY WELL INCREASE INCOME BY CUTTING OUT WHOLE RANGES OF SERVICES AND STAFFS TO INCREASE PROFIT MARGINS, YET REDUCE QUALITY OF CARE. AS YOU RECOGNIZE, INDIVIDUALS IN RURAL AREAS AND IN SMALLER TOWNS AND COMMUNITIES SELDOM HAVE A CHOICE IN HOSPITAL AND NURSING HOME SERVICES. WHERE SUCH LIMITED SERVICES EXIST, IT WILL BE DIFFICULT FOR THE PROVIDER TO OBTAIN A CASE MIX THAT WILL GENERATE INCOME RELATIVE TO THOSE IN MORE URBANIZED AREAS; THIS WILL HAVE AN EFFECT ON THE USE OF TECHNOLOGY, AND AS TO WHICH PROVIDERS CAN AFFORD OR OBTAIN THE LATEST EQUIPMENT OR UPGRADE THAT WHICH THEY HAVE. TO THE EXTENT SOME OF THEIR MORE COSTLY PROCEDURES ARE NOW SUBSIDIZED BY COST REIMBURSEMENT, THEY WILL HAVE LITTLE CHOICE BETWEEN REDUCING SERVICES OR PROFITS, EITHER INCREASING INCOME BY ENSURING A SIGNIFICANT NUMBER OF HIGH REIMBURSEMENT CASES (DIAGNOSES) OR DISCONTINUING SERVICES.

WITH SPECIFIC REFERENCE TO DIAGNOSES GROUPINGS (CASE MIXES) FOR REIMBURSEMENT, THE CARRIER (GOVERNMENT OR CONTRACTUAL ORGANIZATION SUCH AS BLUE CROSS/SHIELD) WILL HAVE LITTLE, IF ANY, CONTROL OVER THE MIX FOR WHICH PAYMENTS WILL BE MADE. NOT FACTORED INTO ANY STUDIES OR CONCLUSIONS IS THAT TREATING AND ADMITTING PHYSICIANS WILL CONTROL THE CASE MIX BY DIAGNOSES. IT WILL BE MEDICAL PERSONNEL, WHO NOT ONLY HAVE AN INTEREST IN THEIR OWN REIMBURSEMENT PROFILES BUT HAVE AN INTEREST IN THAT OF THE PROVIDER, WHO GENERALLY DECIDE THE ADMITTING DIAGNOSES GROUPINGS. ACCORDING TO MATERIAL PREPARED BY THE HEALTH CARE FINANCING

ADMINISTRATION (DRG FACT SHEET), "PROSPECTIVE REIMBURSEMENT BASED ON DRG'S IS OUTCOME ORIENTED. HOSPITALS ARE PAID A SPECIFIC AMOUNT FOR THE ENTIRE TREATMENT OF A PATIENT--IT PROVIDES INCENTIVES TO HOSPITALS TO DEVELOP ECONOMIES IN THE MANAGEMENT OF ITS OVERALL SYSTEM FOR THE DELIVERY OF HEALTH CARE BECAUSE THE HOSPITAL RECEIVES ONE PAYMENT FOR THE TOTAL CARE IT PROVIDES A PATIENT....HOSPITALS WILL NOT HAVE INCENTIVES TO DELIVER LESS CARE TO ANY ONE SPECIFIC INDIVIDUAL, BUT RATHER ALLOCATE THEIR RESOURCES THROUGHOUT THEIR ENTIRE PATIENT POPULATION IN THE MOST COST-EFFECTIVE FASHION".

THE ASSUMPTIONS INHERENT IN THE ABOVE STATEMENT AND THE PROSPECTIVE, RATE SETTING AND DRG SYSTEMS OF REIMBURSEMENT ARE SUSPECT IN THAT WERE MANAGEMENT INCLINED TO OPERATE IN THE MOST COST EFFECTIVE FASHION, DOES EACH AND EVERY FACILITY HAVE THE NECESSARY MANAGEMENT EXPERTISE TO DO SO? IF THERE IS THE NECESSARY EXPERTISE, A DEFINITION OF "MOST COST EFFECTIVE FASHION" HAS NOT BEEN GIVEN. THERE HAS BEEN NO COST BENEFIT ANALYSIS DONE IN WHICH THE LEVEL AND QUALITY OF HEALTH CARE PROVIDED THE POPULATION IS EQUATED TO REDUCTIONS IN REIMBURSEMENT. WHETHER SUCH AN ANALYSIS COULD BE MADE IS QUESTIONABLE, SO THE QUESTION REVERTS TO WHETHER ACCESS TO HEALTH CARE BY THOSE WHO CANNOT PAY WILL BE AVAILABLE WHEN NEEDED? TO SOME EXTENT THAT HAS ALREADY BEEN ANSWERED IN THE NEGATIVE. IN THE FINAL ANALYSIS, THE VARIOUS COST CONTAINMENT SYSTEMS MAY WELL RESULT IN A TWO (OR THREE) TIER HEALTH SYSTEM IN WHICH THOSE WHO MUST RELY UPON FEDERAL, FEDERAL/STATE PROGRAMS WILL "STAND IN LINE" FOR SERVICES WHILE THOSE WHO CAN PAY OUT OF POCKET ARE SERVED ALONG WITH THOSE WHOSE DIAGNOSES WILL PROVIDE FOR THE HIGHEST REIMBURSEMENT.

IN MANY CASES, COST CONTAINMENT WILL PROBABLY RESULT IN PROVIDERS DROPPING ENTIRE GROUPS OF SERVICES IN THEIR LESS PRODUCTIVE COST CENTERS IN ORDER TO ACHIEVE ECONOMY EVEN THOUGH NO SUCH SERVICE MAY BE FURTHER AVAILABLE TO INDIVIDUALS WITHIN COMMUTING DISTANCE.

WITH RESPECT TO SPECIFIC PROBLEMS THAT AFFECT INDIVIDUALS WHO ARE BLIND OR THOSE WITH LOW VISUAL ACUITY, THE DRG SYSTEM FOR PROSPECTIVE REIMBURSEMENT WOULD DISCRIMINATE AGAINST MANY OF THOSE WHO HAVE EYE PROBLEMS THAT MIGHT BE ALLEVIATED BY SURGERY AND OTHER TREATMENTS. FOR EXAMPLE, AN INDIVIDUAL AGE 66 WITH TREATABLE CATARACTS WOULD PROBABLY FALL INTO A LOWER LEVEL REIMBURSABLE CATEGORY AND MAY HAVE TREATMENT DELAYED WHILE THE PROVIDER TREATS THOSE WITH HIGHER REIMBURSEMENT FACTORS. HOWEVER, IF THE FACILITY REMOVED THE CATARACTS THE INDIVIDUAL MIGHT BE PRODUCTIVE AND NEED LESS CARE OF ALL TYPES WHEREAS, ON THE OTHER HAND, HIS OR HER NEEDS FOR MEDICAL CARE AND OTHER SERVICES WOULD INCREASE. GENERALLY, SINCE EYE PROBLEMS DO NOT LEAD TO EXTENDED HOSPITAL BED USAGE, THOSE IN NEED OF SUCH CARE, WITHOUT SOME OTHER "HIGHER LEVEL" DIAGNOSES REQUIRING OTHER TREATMENT, WILL BE IN LINE FOR SERVICE OR RUSHED IN AND OUT TO BUILD UP ADMISSION RATES.

FROM THE USER'S STANDPOINT, THE ONLY BENEFICIAL ASPECT OF THE PROSPECTIVE PAYMENT SYSTEM PROPOSED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IS THAT WHICH PROVIDES FOR TOTAL PAYMENT TO HOSPITALS ON BEHALF OF MEDICARE BENEFICIARIES EXCLUDING DEDUCTIBLE AND CO-INSURANCE, AND THE PROHIBITION ON THE HOSPITALS BILLING MEDICARE BENEFICIARIES ANY COST DIFFERENCES.

INASMUCH AS THE COST OF HEALTH CARE IS INEXTRICABLE FROM THE NATIONAL ECONOMY, WE REALIZE THAT BRINGING DOWN THE COST OF CARE CANNOT

BE DEALT WITH IN ISOLATION. ATTEMPTS TO CONTROL ONE SEGMENT OF THE "INDUSTRY" ONLY CAUSE BULGES IN OTHER PARTS OR DELETION OF SERVICES. THEREFORE, WE PROPOSE A NUMBER OF NEAR AND LONG TERM ACTIONS RATHER THAN ONE MAJOR EFFORT DIRECTED AT HOSPITALS ONLY.

WE PROPOSE THAT THE GOVERNMENT PROVIDE ACTUAL COMPETITION TO HOSPITALS AND MEDICAL PROVIDERS BY FUNDING CLINICS, HOSPITALS AND CARE CENTERS THAT WOULD PROVIDE A FULL RANGE OF SERVICES TO MEDICARE PATIENTS IN HOUSE. THIS WOULD MEAN CONTRACTING WITH DOCTORS, NURSES, HOSPITALS AND OTHERS INSTEAD OF PAYING FEES THROUGH "PLANS". THIS WOULD BE ESPECIALLY HELPFUL IN LARGE URBAN AREAS WHERE SOME HOSPITALS ARE CLOSING ALL OR PART OF THEIR FACILITIES BECAUSE OF FOR-PROFIT ORGANIZATIONS MOVING IN.

FURTHER, THE GOVERNMENT SHOULD ENSURE PROGRAMS FOR TRAINING ADDITIONAL DOCTORS, ASSISTANTS, NURSES AND AIDES TO INCREASE COMPETITION RATHER THAN LETTING THE VARIOUS MEDICAL PROFESSIONS DECIDE HOW MANY PROFESSIONALS ARE NEEDED IN ORDER TO ENSURE HIGH INCOMES.

THE PROVISION OF CARE, NOT BEING LIMITED TO HOSPITALS, SHOULD BE LOOKED AT IN ITS TOTALITY. IN MANY CASES, INCREASED PERSONNEL AND NUMBERS OF NURSING HOME BEDS WOULD RELIEVE DOCTORS AND HOSPITALS OF EXPENSIVE CARE IF THERE WERE SUFFICIENT FACILITIES AND PROPER CARE. IF THE NURSING HOMES WERE IN SUFFICIENT SUPPLY AND PROPERLY STAFFED, MUCH OF THE MEDICAL CARE PROVIDED IN HOSPITALS COULD BE PROVIDED AT A LESSER COST IN THE NURSING HOMES IF A SUFFICIENT NUMBER OF DOCTORS, NURSES AND AIDES WERE ON DUTY. AS IT IS NOW, A SKILLED NURSING FACILITY RECEIVES MEDICARE REIMBURSEMENT FOR A LIMITED TIME ONLY, AND ONLY FOR PROVIDING SPECIFIC NURSING SERVICES AND THERAPIES. MEDICARE COULD BE EXTENDED

TO SERVICES OF A MEDICAL AND NURSING NATURE FOR INDEFINITE PERIODS AND KEEP THE PATIENTS OUT OF THE HOSPITALS. ALSO, ENCOURAGEMENT AND ASSISTANCE SHOULD BE GIVEN TO THE BUILDING OF NURSING CARE FACILITIES IN AREAS WHERE SUCH SERVICES ARE IN SHORT SUPPLY. IN SOME OF THE SMALLER TOWNS AND IN RURAL AREAS, THE FACILITIES HAVE LONG WAITING LISTS WHICH EXTENDS SOME HOSPITAL STAYS. AGAIN, IT IS BOTH PERSONNEL AND FACILITIES THAT ARE NEEDED.

INASMUCH AS PROSPECTIVE PAYMENT SYSTEMS HAVE NOT SHOWN THEMSELVES AS ENCOURAGING HIGH QUALITY FULL SERVICES, IT SHOULD ONLY BE USED AS ONE OF A VARIETY OF EFFORTS. FOR ONE THING, IT SHOULD BE FULLY TESTED UNDER STRICT CONTROLS TO ENSURE ITS EFFICACY, AND IT SHOULD BE TESTED ACROSS THE MEDICAL CARE SPECTRUM, NOT JUST HOSPITALS.

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Statement of the Associated Hospital Systems

Mr. Chairman, I am Merlin K. DuVal, M.D., President and Chief Executive Officer of the Associated Hospital Systems, an association of eleven of the nation's largest non-profit, multi-institutional health care systems. The members of this Association own, operate, manage or provide contract services to over 475 acute care non-profit hospitals. We very much appreciate this opportunity to testify on Medicare prospective payment plans and are eager to participate constructively in this important health policy debate.

Our member systems strongly support reform of the present Medicare retrospective cost-based payment system, which has outlived its usefulness. We are anxious to move toward a payment system which is prospective, which has incentives for efficiency rather than arbitrary caps, and which is based on prices. In an ideal world this would take the form of a per capita payment because it allows greater choice by beneficiaries and more flexibility in the negotiation of provider payment plans. The objectives of such reform should be to promote incentives for efficient and economical provision of hospital services, to strengthen market forces in the hospital sector, to encourage cost consciousness on the part of patients and providers and to reduce the need for government regulation.

Recognizing that this Subcommittee is focusing its attention today on the DRG-based plan, we want to share with you some of our concerns centered on this proposal. Since it is possible that this plan may advance in Congress, we also want to call your attention to several modifications which would in our view make the proposal more equitable and reasonable. We think the plan in its present form puts hospitals at total risk for operating within payment constraints while significant decisions by other providers and patients are clearly outside the control of hospitals. This is not only unfair, but it is an untenable situation. In this regard, we support the testimony of the American Hospital Association which identifies many of the recommendations we will offer to you.

At the outset, Mr. Chairman, we want to express our reservations about the validity of the particular DRG-based plan developed by the Department. A great many assumptions were used in the construction of this plan, many of which have not been validated. More particularly, the Department's plan presumes that errors or ommissions in the recording of clinical data are not likely to produce significant distortions in the calculation of national Medicare rates. In fact, we believe the accuracy of the data is questionable, that the sample of bills from which the diagnostic data is obtained may not be representative of a hospital's Medicare experience and that these problems can indeed produce very significant distortions in national rates. Further, the assumption in the Department's plan that the mix of cases within each of Medicare's proposed national DRG categories approximates the mix of cases in each of an individual hospital's DRG categories is far from verified, and constitutes a potential source of grave errors and inequities in fee payment rates.

Apart from these questions about the reliability of existing data, we are worried about the incentives rewarding low cost, short-term admissions. While there does not appear to be any evidence supporting significant changes in admission rates in New Jersey during their experiment with DRG-based payment, we are concerned about a payment plan which could lead to hospitalization for cases now routinely treated on an ambulatory basis. At the same time we wish to note the potential created by the large variation in the cost of cases within some DRG's for some institutions to screen elective admissions for the purpose of referring more complicated and potentially costly cases to other institutions. Overall, the potential for manipulation of admissions policies must be examined and policy mechanisms explored that assure the appropriateness of admissions and referrals.

In a related area, we want to call your attention to the potential compromise of the objectivity and independence of the hospital medical records system that a DRG-based payment plan may encourage. The matter of so-called "DRG-creep" is, in our view, the possible consequence of basing payment on diagnostic information recorded before the program became effective. Where the selection of and recording of primary and secondary diagnoses can significantly alter payment, the potential for changing past practices in coding medical records exists.

Another concern to our member systems concerns the new administrative costs associated with a DRG-based payment system at the institutional level. We understand that the integration of clinical and financial data systems will be essential to the effective management of a hospital. The expenses of installing and operating such systems are considerable and we do not see any allowance for these expenses in the calculation of DRG rates.

Finally, we assume that the present Medicare policy of responsibility for the payment of beneficiary bad debts will be continued under the DRG plan. We do not find, however, any discussion of this issue in the Department's report to Congress, but we presume that cost sharing would be paid separately by Medicare in the event beneficiaries did not otherwise meet these obligations. This payment could be handled in a manner similar to the pass-through of education and capital costs.

We noted earlier in our statement that we would like to offer some constructive recommendations for the improvement of the Department's plan even though our preference is for an altogether different approach to the reform of Medicare. We also believe that considerable harm will be inflicted on hospitals and Medicare beneficiaries if the present payment policies under TEFRA are continued. We have five specific recommendations which we believe are necessary to improve the present plan.

First, in establishing the rate initially for each DRG, we think it necessary to take account of the practices in the health services market in which a hospital is located. The Department's plan uses Medicare's national average cost experience, adjusted for area wage rates, as the method of setting DRG rates for each hospital. We believe that a regional cost base would be more appropriate as it would take into account other regional cost variances in addition to wages, and avoid the harmful result flowing from excessive over or under payments.

Second, we want to recommend the appointment of an independent panel for the purpose of forecasting the amount of the annual adjustment of DRG rates. The Department's plan reserves this function for the Secretary and leaves to his or her discretion the method for calculating an inflation adjustment and adjustments related to improvements in service or productivity. As an example of what we have in mind we point to the panel of economists appointed in New York for this purpose. Furthermore, we believe that the statute should prescribe the components in detail which should be a part of the method for determining an annual adjustment to Medicare payment rates.

As an aside we would also like to point out our objection to the Department's plan where it fails to require any consideration of the effects of technology and growth in services when the base rates are trended forward to their first year of use. If an allowance for these factors is not provided, the level of the initial rate will be well below the costs incurred to provide the care. Our anxiety over this issue is heightened by the Department's recommendation to delete the one percent technology allowance under the TEFRA target rate formula in FY 1984.

Third, we support the exclusion from the Department's plan of specialized institutions such as pediatric and psychiatric hospitals and long-term care facilities. We recommend that this exclusion be broadened to include other types of specialty hospitals whose services and mix of patients are markedly different from the typical acute care hospitals. These national medical centers, such as cancer hospitals, should be handled separately by Medicare.

Fourth, in our review of the Department's plan we were disturbed to find very little detail about the opportunities for exceptions and adjustments or about the administrative remedies that would be available. We are very much opposed to the proscription of judicial review of payment disputes and recommend that this provision be dropped. Further, we think any legislative proposal embodying the DRG plan should include a description of the grounds for exceptions and special adjustments to the rates along with a description of the administrative remedies open to hospitals.

Fifth, we would like to recommend that any legislation in this area permit the opportunity for continued experimentation with promising alternative payment policies under Medicare. We do not believe the DRG approach has proved itself as the desired payment system, and neither do we believe that enough is known about other payment methodologies. It should be possible for states or systems of hospitals to be granted waivers from the Medicare payment system when they have designed promising experiments. For example, we believe it should be possible for systems of hospitals to negotiate a risk contract with Medicare and receive a per capita payment for the provision of covered services similar to the arrangements now permitted for HMO's and competitive medical plans.

Over the past year our Association has devoted considerable time to the exploration of a number of alternative payment system policies which might best meet these objectives. At the same time we have watched closely the development and enactment of additional cost constraints on the present system for reimbursing hospitals for their services to Medicare beneficiaries. In particular we are convinced that the reimbursement changes in last year's TEFRA will, if continued, do serious damage to the financial viability of many of our nation's hospitals. Further, our review of the Department's DRG-based payment plan gives rise to a number of concerns which we have described in some detail earlier.

Based on our discussions to this point, we believe that the Medicare program should begin moving toward the goal of providing its beneficiaries with the health plan choices available in the private sector. There is a vigorous and increasingly competitive private market for both traditional health insurance plans and for a variety of emerging alternative delivery systems which, for the most part, are not now available to the beneficiaries of Medicare. In short, we envision a new role for Medicare as a financer of the health plan choices made by beneficiaries in the private market. This role would eliminate much of the direct role of the government as the payer for services and as the regulator of the hospital sector -- roles which we believe have not been played effectively.

Our intent is to recommend a certificate plan for Medicare under which the program would annually provide for the purchase of qualified private health plans. The method for determing the initial value of the certificate and for its annual adjustment would be detailed in the statute. In our experience we believe it would be possible to maintain access for Medicare beneficiaries to the present level of benefits while at the same time reducing the uncontrolled financial risk to government that characterizes the present program. We realize, Mr. Chairman, that this is a more controversial change than either TEFRA or the DRG plan of the Department, but we feel that only a fundamental change can resolve the problems ahead for Medicare.

We are aware of the estimates furnished to you concerning the fiscal crisis for Medicare which is rapidly approaching. One consequence of this funding problem could be a precipitous cut in benefits and a loss of access to quality services on the part of Medicare beneficiaries. We share your concern that this outcome not occur. This is in large part the motivation for our development of a plan to protect the integrity of the program and to stimulate efficiency and economy in the provision of health services.

While our certificate plan is not fully developed at this point, we can describe some of the advantages of this type of plan. First, it would rely on the competitive forces of the market to produce economical health plans for the elderly. The purchasing power of the Medicare program would create strong incentives for the development of cost-effective delivery systems in order to be competitive in the Medicare market. Second, it would eliminate the need to construct and operate a nationwide hospital payment system for Medicare. Payments to providers of services would be negotiated by the plans and the providers operating under the discipline of the constraint imposed by the value of the certificate. Finally, it would leave to government the important responsibility of assuring fair competition, consumer protection, and the level of health coverage it is willing to finance.

We supported the expansion of Medicare last year to permit prospective payment of HMO's when selected by Medicare beneficiaries. This provision should be expanded in accordance with a plan to gradually move toward a certificate system as outlined above. It is our strong belief that this approach to Medicare reform is preferable to either the payment changes in TEFRA or the proposed DRG-based payment plan recently submitted by the Department of Health and Human Services.

Mr. Chairman, we have intended to provide you and the Subcommittee with our views about the future design of the Medicare payment system. We think a certificate approach should be developed now and scheduled for implementation when the present special payment provisions of TEFRA expire. We are eager to work with you toward that objective. We believe such a system is our best hope in the long run of meeting the cost-containment requirements of Medicare, and removing government from its hopeless snarl of regulatory efforts. We see TEFRA and DRG's as further "ensnarlments," and do not think they will work.

At the same time we know you are seriously considering the Department's DRG-based payment plan. In our opinion this plan raises a number of concerns, some of which we pointed out to you, and we have made several specific recommendations which we feel are necessary to make that plan equitable and reasonable. Should you favor this plan, we hope you will consider our proposals and that you will continue the opportunity for further study and experimentation with alternative payment policies.

In the final analysis all of us must share equitably in the risks of a new payment policy. Providers, beneficiaries, and payers must all bear some risk for the decisions that result in the provision of health services. We hope you will agree with us that the proposal before you today does not distribute the risks and responsibilities of our health care delivery system fairly.

Again, thank you for this opportunity to testify. We would be pleased to answer any questions you or other members of the Subcommittee may have.

STATEMENT ON BEHALF OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION

by

Howard Strawcutter, M.D.
President

Mr. Chairman, I am Howard Strawcutter, M.D., president of AMPRA and a practicing physician in Lumberton, North Carolina. The American Medical Peer Review Association (AMPRA) includes 137 organizations across the United States. These physician-led organizations provide utilization and quality review services to private and public health insurers, employers and other entities which provide or pay for health care service. More than 100,000 physicians are members of these organizations, representing the full range of medical specialties and practice settings.

AMPRA is the successor organization to the American Association of Professional Standards Review Organizations (AAPSRO). AMPRA fully supported and continues to support the Peer Review Organization provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA) authored by you and Senator Baucus last year. Those amendments made substantial improvements in the system for assuring effective utilization and quality review of the care provided to Medicare and Medicaid patients and provided a significant stimulus for similar review activities in the private sector. Our organization appreciates very much the strong support of this Committee for independent, professional review of medical care. We pledge to continue our efforts to improve the quality and appropriateness of care provided to all patients and to work cooperatively with you toward our shared goals.

As you know, under prior law, PSROs were directed to concentrate their activities, as a first priority, on monitoring hospital admissions and lengths of stay on a concurrent basis. PSROs had considerable success in accomplishing those objectives.

Examples of that success are reflected in the 1981 AMPRA report on PSRO impact which shows that:

- Twenty-two PSROs reduced Medicare and Medicaid average length of stay resulting in a decrease of 504,359 days for savings of almost $41 million.
- Sixteen PSROs reported they saved 113,945 days by reducing days of care per thousand for Medicare and Medicaid resulting in savings of over $9 million.
- The American Red Cross Blood Services covering West Virginia reports a decrease in blood wastage from 10% to 6.7% following a study conducted by the PSRO resulting in savings of $62,868.
- The PSRO in Milwaukee achieved a 33% reduction in the number of repeat x-rays for an estimated cost savings of more than $1.2 million.
- PSROs also reported identifying and correcting utilization and quality problems as follows:
  - Forty-eight PSROs reported correcting 94 problems associated with inappropriate use of ancillary services.
  - Twenty-eight PSROs reported correcting 83 problems in long-term care facilities.
  - Five PSROs reported eleven improvements in the delivery of ambulatory care services.
  - Nine PSROs reported reductions in numbers of admissions to hospitals.

- Seven PSROs reported reductions in admissions/1,000 Medicare or Medicaid beneficiaries.

As long as Medicare reimbursed hospitals primarily on a retrospective reasonable cost basis, the longer a patient stayed in the hospital and the more services provided, the more the hospital was paid. It was quite appropriate under these circumstances for the utilization review process to concentrate to a great degree on monitoring lengths of hospital stays in order to counter these fiscal incentives.

In the determination of how this monitoring should be carried out it was apparent that there was an inherent conflict of interest in hospitals reviewing their own activities with the purpose of reducing their revenues. Furthermore, reviews by agents of Medicare were viewed as suspect on three grounds: first, on grounds that they might be excessively concerned about cost and insufficiently concerned with quality; second, that these agents could not marshall the professional expertise needed to perform the reviews properly; and third, the conflict of interest inherent in a situation where such agents need to maintain the goodwill of the providers of care in their private business. Independent professional peer review presented a mechanism which would not suffer from these problems and would be of sufficient scope to take advantage of economies of scale.

Under the new hospital reimbursement system established by TEFRA and the proposed DRG-based payment plan recommended by the Administration, the financial incentives for hospitals change. For one thing, these systems pay on the basis of hospital stays rather than on the basis of per diem costs for routine services. Under TEFRA and even more under a DRG-based prospective payment system, hospitals can profit not only by increasing efficiency -- the goal -- but also in ways unintended by policy makers. These inappropriate ways include:

1. admitting patients who might be cared for on an outpatient basis;
2. the favoring admission of patients within each DRG whose costs are comparatively low and stays brief;
3. allowing bias to affect the selection of principal diagnosis for a patient with multiple diagnoses in order to obtain higher payments; and
4. withholding clinical services or substituting less expensive services, or delaying use of new technologies in order to reduce the cost from the point of view of the single stay, but possibly inducing greater overall use of services and greater aggregate costs when subsequent stays and services are required.

Mr. Chairman, we are seriously concerned about the potential for any or all of the foregoing responses to occur as a result of the changed financial incentives associated with the TEFRA payment system and with DRG-based prospective reimbursement. Our anxiety is heightened by the Administration's apparent total disregard for any system to monitor the quality and appropriateness of medical care as evidenced in their recommendation to repeal both the PRO statute and the utilization review requirements under Medicare and Medicaid. We do not share the Administration's view that functions performed by PROs or PSROs can be most effectively provided through contracts with fiscal intermediaries. Our experience confirms the fact that peer review, if it is to be effective, must be carried out with the skill of professionals, by physicians in active practice organized at the local level.

We believe the issues involved in quality reviews under DRGs will be more difficult than ever before. For example, if a DRG is established, as proposed, for hospital admissions for pneumonia, there must be an effort made to provide assurance that hospitals are not induced to admit some of the many pneumonia patients now treated properly as outpatients. Furthermore, when there is a financial incentive to reduce the hospital's quantity of services, there must also be an effort to protect the patients against their receiving inadequate care. Such behavior could result in multiple readmissions, possibly at higher aggregate cost. Minimizing cost during a hospital stay is not the objective we seek. Maximizing the cost-effectiveness of care in the aggregate and reducing aggregate costs are the appropriate objectives. These goals require the use of the expertise of professionals in the surveillance of medical practice and in obtaining the cooperation of providers of services in maintaining appropriate standards of practice.

In order to assure that hospitals do not enrich themselves inappropriately by taking advantage of loopholes in the rules of the new Medicare payment game, an effective utilization and quality review system must continue to operate to monitor the hospital's admission practices, its provision of care and diagnostic coding, to conduct evaluations of patient care outcomes, and to initiate corrective actions as necessary. This is the purpose of the PRO law and we urge you to direct the Department of HHS to proceed with the implementation of this law in a timely manner.

The HHS report recommending the adoption of a DRG approach to prospective reimbursement indicates the intention to use PROs in the operation of the DRG payment system. During the implementation phase the report states on page 61 that, "amendments to Peer Review Organization contracts" will be made. Unfortunately, we have been unable to reconcile this position with the recommendation contained in the Administration's FY 1984 budget which calls for the repeal of the PRO law. We urge that you continue to support PROs and take such steps as may be necessary to assure the prompt and reasonable implementation of this law by the Department of HHS.

As you know, Mr. Chairman, members of our Association in the State of New Jersey have been actively involved with the DRG experiment in operation there. You have heard testimony from them and others in New Jersey about the vital importance of this effort to the success of that experiment to date. Our members in other states are prepared to offer the same assistance to Medicare and its beneficiaries so that quality of care and the integrity of the payment system are maintained.

Our members are uniquely qualified to perform the functions required to assure proper medical practices under prospective reimbursement and are anxious to assist in the transition to a more equitable and economical payment system. At the same time we are expanding our review activities through private contracts with insurers, employers and others in the private sector who recognize that broadly-based, community wide quality review programs are key to the promotion of quality and to cost-effective medical care.

AMERICAN OSTEOPATHIC
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STATEMENT OF THE
AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION
SUBMITTED TO THE
SUBCOMMITTEE ON HEALTH
SENATE FINANCE COMMITTEE
FEBRUARY 17, 1983

It is a pleasure to submit this statement to you on behalf of the American Osteopathic Hospital Association (AOHA), the national organization representing the more than 200 osteopathic hospitals spread across 31 states. Our Association Headquarters is in Arlington Heights, Illinois, with an office in Washington, D.C.

Osteopathic Hospital Profile

Our members serve as the primary institutional care facilities for those individual consumers who choose to receive their health care from one of the nearly 20,000 practicing osteopathic physicians in the nation. Osteopathic hospitals have nearly 25,000 beds available and last year treated over 800,000 inpatients and 3,000,000 outpatients.

Many of our hospitals are located in rural and semi-rural areas and all osteopathic hospitals have an historic and philosophical commitment to providing comprehensive, quality health services to people. Nearly half of our hospitals have less than 100 beds and over 80 percent have less than 200 beds, reflecting our special community orientation. Nearly 85% of all osteopathic physicians are primary care practitioners and more than half practice in communities of less than 50,000 persons.

Osteopathic hospitals are also dedicated to medical education. All of our hospitals with 200-299 beds are teaching institutions, while 70 percent with 100-199 beds have teaching programs. These programs produce general practitioners, an identified need of our nation's medical manpower resources.

In addition, our hospitals have had a long, historic tradition of providing the type of innovative community health care services advocated in recent years by the federal government. Our institutions and profession stress wellness and preventive care resulting in a "patient oriented" approach to medical care. The profession is founded in the philosophy of treating the whole person, not just the symptom or disease, because what happens in one part of the body can affect other parts. Wholistic care, family medicine, primary care, and a humanistic "hands-on" approach to treatment have been the hallmarks of the osteopathic profession for over 100 years. The AOHA is proud that our hospitals have been at the cutting edge of these progressive movements within the health care delivery system. With this backdrop, it is our pleasure to convey to the Committee our thoughts on the move toward prospective payment for hospitals and to offer specific policy recommendations for your consideration.

AOHA's Commitment to Prospective Payment

The American Osteopathic Hospital Association has long recognized the necessity to move away from the retroactive cost-based payment system and toward a prospective mechanism with meaningful incentives. As far back as 1977, we forcefully communicated our position to the then Secretary of the Department of Health, Education and Welfare, Joseph Califano. We conveyed our long held view that a vital need existed to "develop new payment mechanisms that will encourage efficient management of our resources and contain rising costs without impairing the capacity of the health care system to meet our patients' needs."

Our long support for a move away from cost-based reimbursement and toward prospective payment was reiterated by AOHA's Board of Trustees in 1978. Our Board was convinced, even then, that retroactive reimbursement was inherently flawed because: it failed to consider the provider's full financial requirements; it lacked any incentives for efficiency; it did not consider the true nature of hospitals costs; and it kept intact barriers to those who cannot afford to pay for care. The problems our Board cited five years ago are even more acute today as witnessed by the continual chipping away of reimbursement through tight retrospective payment controls. Thus, encouraged by the developing consensus emerging within the hospital field and within government, AOHA restated its endorsement of the concept of a prospective fixed-price payment system for hospitals this past May and during the ensuing months fleshed out a series of policy principles.

Progress Toward Prospective Payment

New and different public policy concepts often take years, if ever, to reach the consensus stage. Activity within the past year reveals encouraging signs that the prospective concept has reached that significant plateau.

Action taken by the Congress through the Tax Equity and Fiscal Responsibility Act of 1982 to require the Department of Health and Human Services (DHHS) to submit a prospective plan to the Congress by December 31, 1982, is clear recognition of the support for prospective payment within Congress. The "fast track" the issue is now on further signifies its urgency. AOHA pledges to work in concert with this and other health committees, DHHS and others to develop a workable and equitable program.

Questions Concerning Prospective Payment

A number of important, unresolved policy questions have emerged from our Association's deliberations and the national debate on prospective payment. For example, should we have a single national approach and/or payment methodology or allow states the option to tailor their own programs according to local circumstances? On what basis should payment be set? Should all hospitals be included? What services should be under the prospective rate? For example, should both inpatient and outpatient services be covered or should we begin incrementally by limiting the plan to inpatient? How will teaching costs be handled? How will capital needs be recognized? How can the demand for health services on the part of consumers be addressed? These and other questions have been discussed by AOHA and others and need to be fully aired.

Elements of a Prospective Payment Program

In our view, the DHHS plan is a constructive first step toward a Medicare-only prospective payment program. In particular we support its recognition of the need to consider separately medical education and capital costs.

Recognition of Teaching Costs

This overriding element, in our view, is the essential requirement that any prospective payment approach must include.

As I previously mentioned, osteopathic institutions are unique in that more than half of our hospitals have teaching programs. Interns and residents from 15 osteopathic medical schools train in our institutions. But what really distinguishes our teaching institutions from the non-osteopathic teaching hospital model is that the overwhelming majority of our teaching hospitals are community facilities. I think it is worth repeating that 70 percent of osteopathic hospitals with 100-199 beds are teaching facilities while all of our hospitals with more than 200 beds have medical education programs. Thus,any prospective payment plan must recognize and take into account the costs associated with the osteopathic, community teaching hospital when compared with costs in the non-teaching hospital. In any peer group assignment, the osteopathic teaching hospital will be at a severe competitive and financial disadvantage unless this unique circumstance is recognized through a pass-through for teaching costs. If this is not accomplished, there will be no encouragement for osteopathic institutions to maintain their extensive medical education programs which would have the effect of thwarting the admirable federal health policy objective of training needed primary care physicians, especially those committed to rural health delivery, preventive health care and wellness programs. We are also concerned about how DHHS would calculate the lump sum indirect medical education costs.

Capital Costs

In addressing the capital question we are pleased that DHHS has recognized the need to treat such costs separately. We reject the argument that a pass-through will lead to an explosion of hospital construction. State certificate-of-need laws, financial market conditions, capital availability and other factors provide the necessary checks.

Prospectively Determined Prices for Inpatient and Outpatient Services

While DHHS has proposed an inpatient only prospective payment system, osteopathic hospitals support determining outpatient rates also on a prospective basis. Although the Department argues that a methodology does not exist to achieve this, we suggest paying hospitals for outpatient services on the basis of usual, customary and reasonable charges. Inclusion of outpatient services in the prospective system will prevent cost shifting to those services while also reducing reporting burdens for hospitals.

Basis of Payment and Pricing for Inpatient Services

AOHA recognizes the political reality of a discharge based DRG specific price as the unit of payment. However, we are concerned about mandating a single national average price. We recommend offering a hospital the option of accepting a regional average price or a 3 year phase-in composite price based on:

- 2/3 of the hospitals own specific costs and 1/3 the regional average price during the first year,
- 1/3 of the hospital's own cost and 2/3 of the regional average during the second year and,
- a 100% regional average price during the third year.

Regional groupings should be carefully configured to reflect similar hospital experiences.

The price should also include a legislatively mandated price adjustment for inflation and technology and should financially recognize hospitals that serve high volumes of Medicare and/or low income beneficiaries. In the case of newly constructed hospitals or replacement facilities, AOHA recommends negotiating with a fiscal intermediary the initial year's price.

Assignment/Non Assignment

AOHA believes in an expanded role for the consumer in making decisions about the type of health care services he or she desires to purchase.

We have also held the position for many years that Medicare has the responsibility to meet hospitals full financial requirements. Therefore, while our members support providing incentives for individual institutions to accept the DRG price, we feel that the hospital should also be provided with the option of seeking a broader financial participation by the beneficiary. For example, if a hospital decided to elect the non assignment option, beneficiaries would be notified in advance that they may be required to pay an additional amount for services rendered. Those charges would be publicly disclosed and filed with the intermediary. Thus, the consumer would be fully aware of the hospital's pricing system and would be more involved and sensitive to cost issues. Demand would be affected and "consumer choice" would be incorporated into the prospective payment system.

Special Consideration for Small and Rural Hospitals

Since almost half of our hospitals have less than 100 beds and a number are located in rural or semi-rural communities, we are concerned that the often volatile changes in case mix and volume of admissions that such hospitals experience should be taken into consideration under a prospective payment system. While we support a program covering such institutions, we recommend that an adjustment factor be built into the prospective system for the small and rural facility. This would assist such hospitals in making a transition from the current reimbursement system to a prospective program.

Exceptions and Appeals Process

It is our conclusion that an exceptions and appeals process is essential for a program that is not perfected and lacks experience on a national basis. AOHA supports limiting the exceptions criteria to such factors as the special needs of sole community providers, unusual shifts in the inflation index, unexpected changes in the severity of illness within a hospital's case mix, questionable actions by the administrative body implementing the program, and computation errors.

A system of judicial review also needs to be part of the prospective system. This appeal mechanism should be an independent third party.

Waiver Authority

AOHA strongly favors encouraging states to develop locally tailored alternative and innovative reimbursement mechanisms. This is especially important since the DRG system has not been tested on a national basis. Reimbursement methodologies and knowledge are changing rapidly and while we recognize the necessity to move now to an agreed upon prospective approach, Congress should not stifle experimentation and creativity.

This is especially relevant in osteopathic hospitals. While DRGs may be a political reality, we must be concerned about whether the practice patterns of osteopathic physicians, which differ from allopathic physicians'patterns, would be reflected in a DRG system. Case mix variations in our rural and urban hospitals, our teaching and non teaching institutions, as well as possible overall case mix differences between osteopathic and allopathic hospitals need to be carefully examined. AOHA hopes to be able to further document these concerns in the future by examining the historical experience of a sample of our institutions. Providing a waiver and demonstration authority would also help provide some answers to these questions.

Utilization Control

Utilization review becomesparticularly important for hospitals under a DRG based system. We would recommend exemption from external utilization review for a hospital with an effective internal control program. Under this approach, the federal government would grant "deemed status" to institutions meeting the criteria. Others would be denied payment in cases where it was concluded that admissions were inappropriate or medically unnecessary.

Sunset Provision

Philosophically and politically, AOHA believes it makes common sense for a significantly new approach to reimbursement such as we are proposing to be reevaluated comprehensively after a reasonable amount of time. Thus, we would recommend that any prospective payment plan include a "sunset" provision preferably after a 5 year period.

Conclusion

Prospective payment is different things to different individuals and groups. During this fast moving legislative debate differences in specific approaches have surfaced and a consensus on details will be harder to reach. We have seen this occur through the years with other policy initiatives and worry that this might happen again with prospective payment. Osteopathic hospitals do not want to see the momentum lost. While we fully recognize that prospective payment is not a panacea for the complex health care problems we face, it is a step toward common sense and equity in federal hospital payment policy.

We thank you for the opportunity to submit our views to you today and pledge our cooperation in working with you in developing a equitable prospective payment system under Medicare.

Martin A. Wall
Director of Government Relations

AAPS

ASSOCIATION OF AMERICAN
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January 27, 1983

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Mr. Robert E. Lighthizer
Chief Majority Counsel
Committee on Finance
U.S. Senate,
2227 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Lighthizer:

We understand that the Subcommittee on Health of the Senate Finance Committee has scheduled hearings on February 17 on HHS' proposal for prospective payments under medicare based on Diagnostic Related Groups.

The Association of American Physicians and Surgeons, Inc., and the New Jersey State Medical Society jointly request the opportunity to testify before the Subcommittee on this occasion.

Our proposed witness is Frank J. Primich, M.D., who is eminently qualified to discuss the impact of the New Jersey DRG experience with particular emphasis on the quality of health care and the practice of medicine.

Dr. Primich, a physician and resident of North Bergen, N.J., is president of the medical staff of Riverside General Hospital, Secaucus, N.J. He is chairman of the Committee on Diagnostic Related Groups of the New Jersey State Medical Society. He also is a member of the Board of Directors of AAPS, which is a national organization of physicians of all specialties dedicated to the preservation of the practice of private medicine.

Dr. Primich has been a keen observer of the New Jersey DRG program since its inception. He has written a number of articles on the program, notably in the February, October and November, 1982 issues of Private Practice magazine (attached).

Annual Meeting, September 22-24, 1983, Hyatt Regency, Columbus, Ohio

As can be inferred from Dr. Primich's writings, he is opposed to the prospective payment DRG plan both in principle and in practice, and will be able to cite specific examples of how this plan in New Jersey has adversely affected patient care and standards of quality medical treatment.

Both the New Jersey State Medical Society and our organization, AAPS, believe that testimony of proponents of this plan must be balanced by voices speaking on behalf of quality and compassion in medical treatment. For the Federal government to adopt the HHS proposal, which is based almost exclusively on cost-effectiveness, would be to negate elements of patient care many physicians believe are essential.

We believe that this viewpoint and our testimony will represent the concerns of the majority of physicians in private practice, not only in New Jersey but nationally. Our testimony will be constructive, and will permit the members to hear aspects of this question they most likely otherwise would not have presented to them.

We will be delighted to work with your staff on details of the hearing, and await confirmation from you regarding the scheduling of Dr. Primich.

Respectfully,

Charles R Ord

cr/s

Charles R. Ord
Executive Director

cc: Senator David Durenberger
Chairman, Subcommittee on Health

Mr. Vincent A. Maressa
Executive Director
NJ State Medical Society

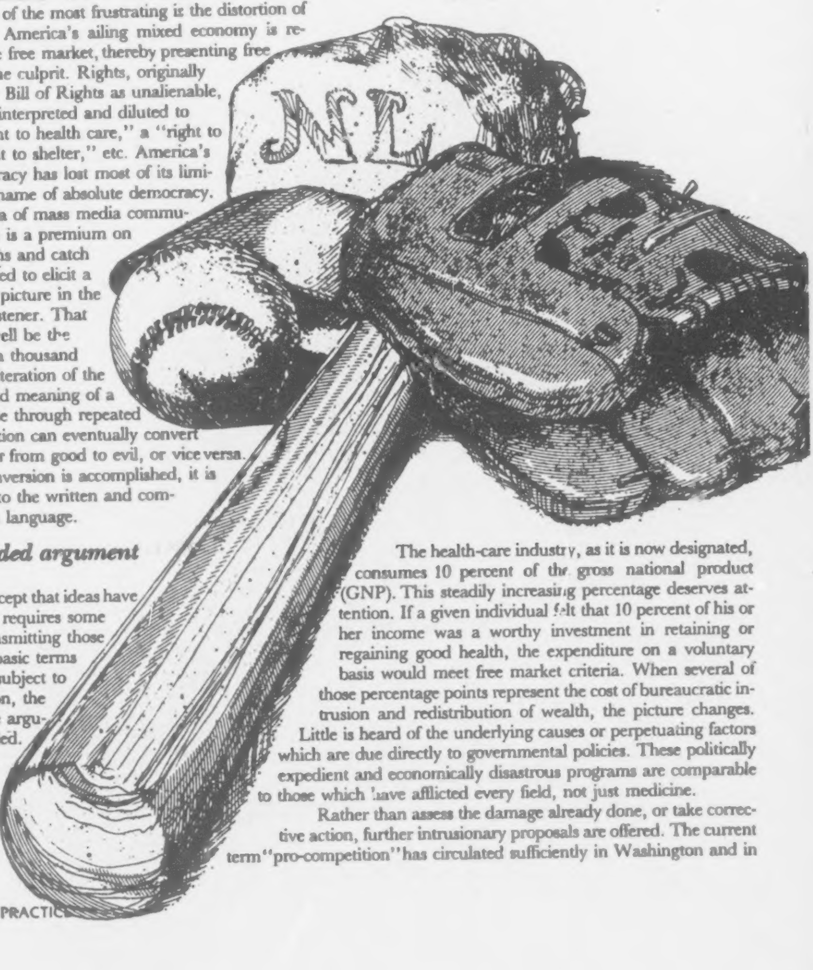
Frank J. Primich, M.D.

THE PRO-COMPETITION CON GAME

by Frank J. Primich, MD

Advocates of "That government which governs least, governs best..." encounter numerous obstacles. One of the most frustrating is the distortion of our language. America's ailing mixed economy is referred to as the free market, thereby presenting free enterprise as the culprit. Rights, originally granted by the Bill of Rights as unalienable, have been misinterpreted and diluted to include a "right to health care," a "right to food," a "right to shelter," etc. America's limited democracy has lost most of its limitations in the name of absolute democracy.

In this era of mass media communications there is a premium on brevity. Slogans and catch phrases are used to elicit a representative picture in the mind of the listener. That picture may well be the equivalent of a thousand words. Any alteration of the commonly held meaning of a word or phrase through repeated misrepresentation can eventually convert its connotation from good to evil, or vice versa. Once that conversion is accomplished, it is assimilated into the written and commonly spoken language.



Clouded argument

The concept that ideas have consequences requires some means of transmitting those ideas. If the basic terms involved are subject to gross distortion, the validity of the argument is clouded. This permits bad ideas to flourish, while good ones often wither.

The health-care industry, as it is now designated, consumes 10 percent of the gross national product (GNP). This steadily increasing percentage deserves attention. If a given individual felt that 10 percent of his or her income was a worthy investment in retaining or regaining good health, the expenditure on a voluntary basis would meet free market criteria. When several of those percentage points represent the cost of bureaucratic intrusion and redistribution of wealth, the picture changes. Little is heard of the underlying causes or perpetuating factors which are due directly to governmental policies. These politically expedient and economically disastrous programs are comparable to those which have afflicted every field, not just medicine.

Rather than assess the damage already done, or take corrective action, further intrusionary proposals are offered. The current term "pro-competition" has circulated sufficiently in Washington and in the news media to gain a place in contemporary jargon. It is a simple term. It means favoring competition; or does it? This version subsidizes half of the competitors, mandates their inclusion in any considerations and toys with tax incentives as a cure for irresponsibility on the part of the participants. The most ominous fact is that there is support for the concept from many supposedly conservative legislators who pay lip-service to free enterprise.

Erroneous statistics

An example dates back 10 years to Hudson County, New Jersey, suffering from a hospital bed shortage. That condition was self-evident since all the desirable hospitals had waiting lists for admissions. A group of physicians decided to try to build a proprietary (for profit) hospital. A feasibility study confirmed the projected need, and the required variances and permissions were sought. A major obstacle was the State Department of Health's stance that the area was already overbedded. This stance was based on outdated and inaccurate figures. Armed with the current and more valid data, the doctors prepared to do battle. The confrontation was hardly what they expected; the commissioner of the Department of Health readily conceded his department's estimates were grossly incorrect. In the name of "fairness," however, correction was not possible, since these erroneous statistics had been used to deny previous applicants.

> ***Since most of the deficit was suffered by city, county and state hospitals, it necessitated annual bail outs with tax money.***

Eventually, through persistent effort, the doctors' dream became a reality. Riverside General Hospital in the Hackensack Meadowlands opened its doors in 1976. Today it is running beyond its 200-bed capacity. It is now the first choice of patients in the community. It is showing a profit, and therein lies the rub. The State Department of Health has declared profit in a health-care facility to be improper and immoral, and has openly stated its intention to obliterate the situation. Of the six proprietary general hospitals in the state when Riverside opened, the other five have recouped their investment as best they could and moved on to greener pastures. All cited overregulation and the hostile attitude of the regulators as their reason for leaving. Currently, the shareholders of Riverside are seriously considering its sale as the only viable alternative.

The second example bodes ill for the rest of the nation. New Jersey is conducting a federally funded "experiment" for the Department of Health and Human Services (HHS) on the use of diagnosis related groupings (DRGs) to determine hospitals' reimbursement. This kamekaze pilot study is predicated upon assigned values according to diagnosis rather than time or services rendered (as discussed in "Experimenting with DRGs," February 1982). It is sufficient to note that the program is inequitable in a pluralistic payer system.

Any use of human beings for experimental purposes, in this country, has been understood to be on a voluntary basis. A number of suits have been filed against the government for the supposed experimental use of prisoners or military personnel without their explicit permission. DRGs were advanced in New Jersey as a limited voluntary experiment, thereby minimizing initial objections. The original proposal was to study 26 hospitals with the appropriate case mix. Only 10 volunteered, all were inner-city hospitals, which stood to benefit from any change. An additional 16 hospitals were "selected" for participation in order to provide the desired data base. That was 1980. Without any evaluation of the results, 40 more hospitals were ordered into the program in 1981. The remaining 50 were inducted in January of 1982. Fear of a possible change in federal funding by the new administration in Washington may have been behind this haste, but lack of organized resistance and inaccurate information are more likely reasons.

Bizarre system

This bizarre system, for all its faults, is really a side issue. The law (New Jersey S446) which invited this disruption intended to resolve some of the apparent inequities in hospital billing, but was primarily designed to shift the cost of unpaid hospital bills, which amounted to more than $100 million a year. Since most of the deficit was suffered by city, county and state hospitals, it necessitated annual bail outs with tax money. Inefficiency, waste and prevalent political patronage in these institutions stirred up taxpayer resentment and criticism. Under DRGs the "uncompensated cost component" is prorated among the various payers. Insurance premiums are skyrocketing to the displeasure of subscribers. New Jersey Blue Cross, which insures 40 percent of the New Jerseyans, was granted a 26 percent increase this year, but insists this is not enough to avoid insolvency.

Ongoing comments regarding the program in the press and electronic media are based almost exclusively

Continued on page 20

Prescribing information

INDICATIONS — For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS — Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

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REFERENCES — 1. Biagi GL et al: J Med Chemistry 23:2, 1980, pp 193-201. 2. Shader RI, Greenblatt DJ: Br J Clin Pharmac 11(S-1), 1981, pp 5S-9S. 3. Mielke DH, Goethe JW: Proceedings of Symposium, *Anxiety: The Therapeutic Dilemma*, Monograph 97-0665, 1981, p 2. 4. Mielke DH, Winstead DK: Proceedings of Symposium, *Anxiety: The Therapeutic Dilemma*, Monograph 97-0666, 1981, p 6. 5. Hollister LE: Proceedings of Symposium, *Anxiety: The Therapeutic Dilemma*, Monograph 97-0663, 1981, p 7-11. 6. Snyder SH: Proceedings of Symposium, *Anxiety: The Therapeutic Dilemma*, Monograph 97-0644, 1981, p 7.

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Con Game

Continued from page 17

on the evaluations of the Health Department. As might be expected, bureaucratic officials claim cost savings. By proper manipulation of the figures, "savings" to the government can be shown. Even if this were to result in a tax refund, an unlikely possibility, it would not represent a net gain. Increased insurance premiums and out-of-pocket expenses would amount to the equivalent—or more. It is best described as picking the taxpayer's other pocket.

Punishing productivity

It is interesting to note how this mandatory cost containment approach of setting price controls relates to Riverside General Hospital. Since each hospital's rates are set individually, the question of profit, or return on investment, had to be addressed. The dictate was that there would be a small allowance in 1981, half that amount this year, and none in 1983! Any profit beyond the current year would have to depend upon further efficiency. Since the current profits reflect the high efficiency of the present operation, further improvement was very unlikely. Profits, in the future, could only be achieved by cutting corners on the provision of adequate care. There are few better examples of a system which punishes productivity and efficiency in order to reward the inept.

The National League would be composed entirely of the public sector. Using a fixed proportion of tax revenues, the government would take full responsibility for the health care of its employees and all those it deems to be its wards. Using existing government institutions, staffed by those who choose to work within the system and directed by the central planners, such a public system could be held directly accountable.

If competition is to be seriously considered, another approach deserves a hearing. In this proposal, the competition would resemble baseball, the national game. The National League would be composed entirely of the public sector. Using a fixed proportion of tax revenues, the government would take full responsibility for the health care of its employees and all those it deems to be its wards. Using existing governmental institutions, staffed by those who choose to work within the system and directed by the central planners, such a public system could be held directly accountable for the results. The American League (private sector) would operate on a basis of fee-for-service, augmented by private insurance for catastrophic costs as well as reasonable coinsurance (adequate deductibles) for the moderate or higher expenses. Intra-league competition in this group would assure the improved quality and progress once called the "American way."

Such a system would give freedom to the scapegoats. It would do little to improve the lot of the truly needy, but we would be in a position to offer truly charitable help. Most important is the fact that it would lay to rest, once and for all, the myth that big brother knows best.

DIVIDE & CONQUER

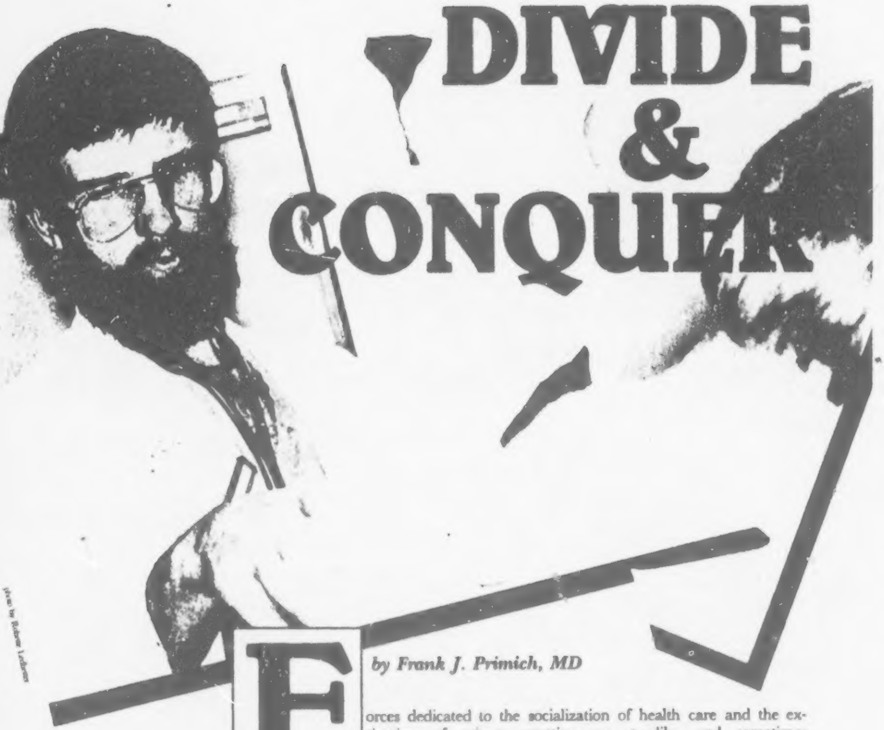

photo by Robert Ledbetter

by Frank J. Primich, MD

Forces dedicated to the socialization of health care and the extinction of private practice are steadily, and sometimes stealthily, advancing their cause. The method may be largely accidental, but the cumulative effect will be no less devastating. Regulations, aimed at perceived flaws in the health-care system, characteristically compound the specific problem, thereby justifying further regulation. This vicious cycle progressively broadens, making resistance more and more difficult. The various segments within the health-care field tend to lose sight of their mutual dependence. In a desperate effort to cope with illogical mandates from government, policies are adopted which have a divisive impact—negating any realistic hope of organized resistance.

The issue of diagnosis related groupings (DRGs), a method of hospital reimbursement based on diagnosis, rather than time or services rendered, offers an object lesson. The program was forcefully introduced in New Jersey as an "experiment" for the rest of the nation. In the February 1982 issue of *Private Practice*, a warning of its ominous threat appeared. Six months later, in preparing a follow-up report, the projected course appears to have been accurate. The cast of characters has changed only

Continued on page 36

Brief Summary

MINOCIN® Minocycline HCl
Oral and Intravenous

CONTRAINDICATIONS: Hypersensitivity to any tetracycline.

WARNINGS: In the presence of renal dysfunction, intravenous use, particularly in pregnancy, in daily doses exceeding 2 grams has been associated with deaths through liver failure. When need for intensive treatment outweighs potential dangers, perform renal and liver function tests before and during therapy; also follow serum concentrations. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. This hazard is of particular importance in parenteral use in pregnant or post-partum patients with pyelonephritis. In such cases, the blood level should not exceed 15 mcgm/ml and liver function tests should be made at frequent intervals. Do not prescribe other potentially hepatotoxic drugs concomitantly. THE USE OF TETRACYCLINES DURING TOOTH DEVELOPMENT (LAST HALF OF PREGNANCY, INFANCY AND CHILDHOOD TO THE AGE OF 8 YEARS) MAY CAUSE PERMANENT DISCOLORATION OF THE TEETH (YELLOW-GRAY-BROWN). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. TETRACYCLINES, THEREFORE, SHOULD NOT BE USED IN THIS AGE GROUP UNLESS OTHER DRUGS ARE NOT LIKELY TO BE EFFECTIVE OR ARE CONTRAINDICATED. Photosensitivity, manifested by an exaggerated sunburn reaction, has been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity is rarely reported with MINOCIN Minocycline HCl. The antianabolic action of tetracycline may cause an increase in BUN. In patients with significantly impaired renal function, higher serum levels of tetracycline may lead to azotemia, hyperphosphatemia and acidosis. CNS side effects (light-headedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug. *Pregnancy:* In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. *Newborns, infants and children:* All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg/kg every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

PRECAUTIONS: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, discontinue and institute appropriate therapy. In venereal diseases, when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (*e.g.*, renal, hepatic and hematopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

ADVERSE REACTIONS: *GI:* (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). Pigmentation of the skin and mucous membranes has been reported. *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

CNS: (see "Warnings"). When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Rapid administration is to be avoided. Parenteral therapy is indicated only when oral therapy is not adequate or tolerated. Oral therapy should be instituted as soon as possible. If intravenous therapy is given over prolonged periods of time, thrombophlebitis may result.

CONCOMITANT THERAPY: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

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Divide & Conquer

Continued from page 33

slightly, but the positions of the individuals and organizations have, in some instances, changed appreciably.

Cast of characters

New Jersey Gov. Thomas Kean, as predicted, has adopted the "wait and see" position. As a "moderate" Republican, he campaigned for decontrol and a better business climate. Since being elected, he has been preoccupied with balancing the New Jersey budget, while retaining entitlement programs and regulatory agencies. His pre-election promise of employing a practicing New Jersey physician as commissioner of health was abandoned, despite the presence of an excellent candidate. His major appeal to voters in the medical community was the promise that they would be rid of the incumbent commissioner of health, who had mandated the DRG program.

Appointed "commissar"

Joanne Finley, MD, the ex-commissioner, is currently functioning as an "adviser" to the New Jersey Health Department on DRGs because of her familiarity with the system. She also is the leading proponent of the supposed benefits of the program. (See the July 1982 issue of *Private Practice*, Letters section.) If the concept were to be adopted on a national basis, she might well be appointed "commissar."

Joseph Morris felt that "control of doctors" was the only missing ingredient to ensured success of the program. He has continued as an assistant to the commissioner of health, and is the chief spokesman for the "merits" of DRGs in New Jersey.

Errors and inequities

Most upper-level bureaucrats of the previous administration's health department are now in the private sector. Their expertise is in demand for the negotiations necessary to appeal the innumerable errors and inequities inherent in the reimbursement process. Their familiarity with the process and the processors is invaluable. If the worst evolves, they will be highly qualified for posts in Washington, D.C.

Shirley Mayer, MD, the new commissioner, has credentials that are predominently bureaucratic, and she projects the impression that only the government can resolve socioeconomic problems. However, she recently submitted a request to the Department of Health and Human Services (HHS) that self-pay patients be exempted from DRG billing. For most insurers, the major inequities of the program are claimed to average out. For the individual who received a disproportionate bill, there is no equalizer.

The New Jersey Hospital Association (NJHA) changed its original position from opposition to neutrality when faced with the threat of defection by those hospitals that perceived the program as their best hope for survival. The NJHA has now adopted a position favoring DRGs. This turnabout is due to the pragmatic advantages that any new program offers initially. Those officials with hospitals in dire straights because enough of the expenses could

Divide & Conquer

not be "cost shifted" have favored the program since its inception. The "efficient" hospital administrators contend, for the time being, they can operate within the system and realize a greater return than before. When the built-in ratchet effect of future cost-containment provisions catches up to these administrators, they will be forced to face the problem. Then they may choose to fight, but their present reaction suggests that cutting quality and rationing care are more likely results.

The American Medical Association (AMA) is in the "wait and see" camp. They are relying on the Health Research & Education Trust, which they help to subsidize, for their evaluation. Dr. Finley is a member of that group which includes, among others, representatives of the American Hospital Association (AHA) and the AMA.

James Todd, MD, AMA trustee, is the physician representative. He is guilty of nothing worse than open-mindedness when he states, "The program has good and bad features."

Vincent Maressa, executive director of the Medical Society of New Jersey, (MSNJ), agrees with Dr. Todd's evaluation, but adds, "Most of the good accrues to hospitals, while most of the bad affects doctors and patients, not to mention those who are paying the bills!"

"Most of the good accrues to hospitals, while most of the bad affects doctors and patients, not to mention those who are paying the bills!"

Leading the battle

The MSNJ has belatedly taken over the leading role in the battle to repeal DRGs. Its previously cordial relationship with the NJHA is becoming more strained. The predicted adversary relationship between physicians and hospitals is growing daily. Anyone interested in disrupting the old system would be hard pressed to find a better way to "divide and conquer."

The New Jersey Business Group for Health is a newly formed organization with good reason to oppose DRGs. It is composed of companies which self-insure, or pay premiums on the basis of their experience rate. The escalation of their costs resulting from this "cost-containing" program is a clear and present danger to their economic survival. While their focus and priorities may vary slightly from those of the MSNJ, a mutuality of common goals exists. At present, this encouraging merger will hopefully coordinate independent efforts.

New Jersey Blue Cross has yet to come out of the closet. Its low-key opposition to the huge increase in costs may have been necessary in order to obtain approval from the insurance commissioner for pass-along premium increases of more than 40 percent for 1982 to individual and small group subscribers. The MSNJ, which offers a Blue Cross policy to its members, has projected a 60 percent increase for this year. Apparently, doctors are sicker than patients.

Minimal coverage

New Jersey's major newspapers, which share a strong liberal leaning, have given minimal coverage to the shortcomings of DRGs. Mention is usually included along with inflation and increased health-care costs in accounting for Blue Cross premium increases. There is usually an accompany-

Continued on page 40

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References: 1. Craig JW. Clinical implications of the new diabetes classification. *Postgrad Med* 68 (No. 4):122-133, October 1980. 2. Yalow RS, Berson SA: Immunoassay of endogenous plasma insulin in man. *J Clin Invest* 39:1157-1175, July 1960.

BRIEF SUMMARY
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Contraindications: Diabinese is not indicated in patients having juvenile or growth-onset diabetes mellitus, severe or unstable "brittle" diabetes, and diabetes complicated by ketosis and acidosis, diabetic coma, major surgery, severe infection, or severe trauma. Diabinese is contraindicated during pregnancy. Serious consideration should be given to the potential hazard of its use in women of childbearing age who may become pregnant.
Diabinese is contraindicated in patients with serious impairment of hepatic, renal, or thyroid function.
Precautions: Use chlorpropamide with caution with barbiturates, in patients with Addison's disease or in those ingesting alcohol, antibacterial sulfonamides, phenylbutazone, salicylates, probenecid, dicoumarol or MAO inhibitors.
Warnings: DIABINESE (CHLORPROPAMIDE) SHOULD NOT BE USED IN JUVENILE DIABETES OR IN DIABETES COMPLICATED BY ACIDOSIS, COMA, SEVERE INFECTION, MAJOR SURGICAL PROCEDURES, SEVERE TRAUMA, SEVERE DIARRHEA, NAUSEA AND VOMITING, ETC.
HYPOGLYCEMIA, IF IT OCCURS, MAY BE PROLONGED.
Adverse Reactions: Usually dose-related and generally respond to reduction or withdrawal of therapy. Generally transient and not of a serious nature and include anorexia, nausea, vomiting and gastrointestinal intolerance, weakness and paresthesias.
Certain untoward reactions associated with idiosyncrasy or hypersensitivity have occasionally occurred, including jaundice (rarely associated with severe diarrhea and bleeding), skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis, and probably depression of formed elements of the blood. With a few exceptions, these manifestations have been mild and readily reversible on the withdrawal of the drug.
Diabinese should be discontinued promptly when the development of sensitivity is suspected.
Jaundice has been reported, and is usually promptly reversible on discontinuance of therapy. THE OCCURRENCE OF PROGRESSIVE ALKALINE PHOSPHATASE ELEVATION SHOULD SUGGEST THE POSSIBILITY OF INCIPIENT JAUNDICE AND CONSTITUTES AN INDICATION FOR WITHDRAWAL OF THE DRUG.
Leukopenia, thrombocytopenia and mild anemia, which occur occasionally, are generally benign and revert to normal, following cessation of the drug.
Cases of aplastic anemia and agranulocytosis, generally similar to blood dyscrasias associated with other sulfonylureas, have been reported.
BECAUSE OF THE PROLONGED HYPOGLYCEMIC ACTION OF DIABINESE, PATIENTS WHO BECOME HYPOGLYCEMIC DURING THERAPY WITH THIS DRUG REQUIRE CLOSE SUPERVISION FOR A MINIMUM PERIOD OF 3 TO 5 DAYS, during which time frequent feedings or glucose administration are essential. The anorectic patient or the profoundly hypoglycemic patient should be hospitalized.
Rare cases of phototoxic reactions have been reported. Edema associated with hyponatremia has been infrequently reported. It is usually readily reversible when medication is discontinued.
Dosage: The mild to moderately severe, middle-aged, stable diabetic should be started on 250 mg daily. Because the geriatric diabetic patient appears to be more sensitive to the hypoglycemic effect of sulfonylurea drugs, older patients should be started on smaller amounts of Diabinese, in the range of 100 to 125 mg daily.
After five to seven days following initiation of therapy, dosage may be adjusted upward or downward in increments of 50 to 125 mg at intervals of three to five days. Patients who do not respond completely to 500 mg daily will usually not respond to higher doses. Maintenance doses above 750 mg daily should be avoided.
Supply: 100 mg and 250 mg, blue, 'D'-shaped, scored tablets.
More detailed professional information available on request.

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Continued from page 37

ing comment by some New Jersey Department of Health spokesman lauding the anticipated "cost-savings." No mention is made of whom is saving, or at whose expense.

New Jersey Sen. Garrett Hagedorn strongly supported a proposed moratorium on the extention of DRGs beyond the initial 26 hospitals. But after waiting patiently for the new administration to take some definitive action, he has called for an open hearing before the New Jersey Senate committee overseeing the program.

Prospective payment

The Sub-Committee on Health of the U.S. Senate Committee on Finance held hearings in late June on state hospital payment systems. These "public hearings" were only publicized after the fact. The witnesses were primarily those who administered the programs, each advocating their particular approach.

Sen. David Durenberger, chairman of the sub-committee and advocate of expanding professional standards review organizations (PSROs), presented himself as favoring free market competition. He blamed retrospective reimbursement for a multitude of sins, and expressed hope that a solution to hospital cost escalation might be found in one of the innovative methods of "prospective payment." That is the new catch word which diverts attention from the feature that all these programs share in common.

Prospective payment is a deceptive term for state control of rates. No consideration is given to the prospect that any of the projected possible benefits could apply in a voluntary system. The mandatory, often arbitrary, nature of the implementation of the growing variety of state regulatory programs compounds the conceded problems inherent in each. Lengthy dissertations on the noble intentions invariably boil down to minimal expectations. Implications of self-serving dishonesty on the part of providers is the justification offered, while honesty and cooperation of the same individuals and institutions is stated to be indispensable to success.

More regulation

Even the most avid advocates of regulation admit there are good and bad features to their specific proposals. On review, this might be compared to the Communist Manifesto. The good part is that it sounds promising. The bad part is that it does not work. The worst aspect is that once established, repeal becomes the least-likely approach to resolving the newly created problems. More regulation and increased funding of the regulators invariably follows.

In total disregard of the principles which govern a free market, the main advantage claimed for regulated prospective hospital rates is that future revenue could be determined beforehand, and budgets adjusted accordingly. Aside from the economic fallacy of central planning, the regulatory process precludes this possibility.

Donald W. Davis, president of Hunterdon Medical Center, located in Flemington, N.J., shared some interesting data on the subject. After the

Divide & Conquer

customary concession of a few theoretical good points to the DRG program, he pointed out the actualities involved in implementation. First, he stated, "The rate review in New Jersey has not been prospective." Hunterdon Medical Center, on DRGs since 1980, did not receive rates for 1980 until Jan. 11, 1980, which became effective May 1, 1980. The 1981 rates were issued March 16, 1981, and became effective April 1, 1981. The 1982 rates, issued Feb. 18, 1982, became effective June 1, 1982. In addition to those delays, changes in the reimbursement methodology resulted in mid-year adjustments. Appeal items account for further delay and uncertainty. The final reconciliation process for the year 1980 had been completed for only three of the original 26 hospitals in the system as of June 1982. Currently, DRGs apply to all 110 New Jersey hospitals. Extrapolation of the above figures paints a horrendous picture of the future. The uncertainties are apparently far greater now than they ever were in the past.

Current figures show that government—federal, state and local—is paying more than half of the nation's hospital costs, with that proportion growing annually.

Growing complexity

In his testimony, Davis also presented the growing complexity of the system with each effort jo correct identified inequities, and the lack of coordination of the rate setting process with licensure requirements and planning agency decisions. He summed up the situation with this comment, "The more complex the system, the more time we spend in managing the system rather than the hospital. Each refinement seems to lead to more management on the state level and less within the local community and hospital."

The American Hospital Association (AHA) reflects the NJHA turnabout, and is promoting a prospective rate program of its own.

Jack Owen, a leading lobbyist for the AHA in Washington and a likely andidate to head that organization in 1984, is someone you will be hearing more of in the future. As a strong force in the NJHA, his position relative to physicians was usually negotiable. He presented reasonable arguments and was felt to fully appreciate the necessity of balancing the benefits and hardhips that policy changes bring to all concerned. In recent years he has inreasingly advanced those hospital-based services which practicing physicians erceive as unfair competition and invasion of their turf. He was seriously onsidered by Gov. Kean for the post of commissioner of health. The current aw requires that the position be filled by an MD. The necessity of changing he law, and the politics involved, along with the MSNJ's "lack of enhusiasm," resulted in abandonment of the idea. Because he is extremely peronable, he may prove to be a formidable adversary.

Semi-socialism

Current figures show that government—federal, state and local—is "paying" more than half of the nation's hospital costs, with that proportion rowing annually. This semi-socialized situation may have passed the point of no return. If there is to be any change in direction, it will require full ooperation and mutual support of the medical and hospital communities. Unfortunately, coping with the ever-increasing assortment of governmental ntrusions is threatening to shatter that traditional alliance.

TESTIMONY OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Mr. Chairman:

This testimony is presented on behalf of the American Association of Nurse Anesthetists (AANA), an association of some 20,000 certified registered nurse anesthetists. Of our members who are still in active practice, approximately 60% are hospital employees and the remainder are primarily employees of anesthesiologists. A small percentage of our members in practice are self-employed nurse anesthetists.

Our organization, like many other organizations of health professionals including the American Nurses Association, has been disturbed by the rapid growth of the costs of health care which has the effect of making necessary care less affordable to most Americans, particularly the aged and less well-to-do. In this connection, we have been proponents of numerous methods to improve the delivery of health care and make it more affordable and of the highest quality. We have been supporters of efforts to expand ambulatory care programs such as the ambulatory surgical centers. We are also proponents of efforts to directly reimburse certified registered nurse anesthetists and other qualified health practitioners in order to stimulate competition among those qualified to deliver helath care. This competition, in our opinion, could well be an important element in substantially reducing health care costs.

Since many of our members are hospital employees, and some of our members are suppliers of services under contract to hospitals, we are obviously concerned with all major changes in the methods of paying hospitals for the care delivery. While we are certainly supportive of methods to reasonably contain costs and thereby make quality care more affordable, we are concerned lest the budget axe eliminate needed services.

There are two specific issues which we would like to raise with regard to the DHHS Prospective Payment System proposal. The first issue has to do with the possibility that hospitals may attempt to shift programs and costs from the hospital to professionals or providers who are not subject to the limits of the proposed Prospective Payment System. Since the System does not in any way limit billings under Part B by physicians, there would seem to be an incentive for a hospital to shift its inpatient programs to physicians wherever it is practical, in a professional and economic sense, to do so. In this connection, testimony on the Prospective Payment System which has been received by the Committee has already raised the problem of radiology programs and laboratories being shifted from the hospital to radiologists with the laboratories being leased to the radiologists. We think there is a similar possibility in the field of anesthesia care. The anesthesia department in a hospital, constituted by employed certified registered nurse anesthetists, could be shifted to a physician group, assuming it was willing to employ the CRNAs. The physician group would then have an agreement with the hospital to provide anesthesia services, thereby continuing the availability of the services. The group would then bill Part B of Medicare for the services delivered by the anesthesiologists and the CRNAs. Thus, the entire cost of operating the anesthesia service in the hospital, with the possible exemption of the cost of equipment and supplies, could be shifted outside of the Prospective Payment System limits.

We are terribly concerned that this kind of cost shifting will result in possibly greater cost and a lesser level of care being provided to Medicare beneficiaries. In addition, it would serve to limit the options which nurse anesthetists have for participating in the health care system. Since nurse anesthesists are not presently permitted to directly bill Medicare under Part B, and since contracting with Medicare to supply services would not rid the hospital of the anesthesia service as a hospital cost, the only alternative for practicing anesthesia for the CRNA would be the somewhat forced employment with the physician group.

We are aware that the Department of Health & Human Services has indicated in its Report to Congress on Prospective Payment that it is very concerned about "duplicate payments". By this we take it to mean that the Department does not want to see programs which had formerly been in the cost base of hospitals, and therefore part of the Prospective Payment per case, be shifted to another billing agent such as a physician who could bill Medicare for the service which is already being paid for in the Prospective Payment. We are troubled, however, because there seems to be no method proposed for effectively dealing with this problem. In addition, the problem cannot be dealt with through a meat ax approach which attempts to prevent hospitals from making any change in prior practice. Obviously, there may be a number of innovations which hospitals should undertake which would involve changing patterns of service so that other professionals or providers might, in future years, be providing the service which the hospital inpatient program had formerly provided. This would be the case, for example, if Medicare recognized certified registered nurse anesthetists as eligible for direct reimbursement for services delivered in a hospital setting to hospital inpatients.

Certainly, the problem of shifting programs and costs to other providers and professionals will not be appropriately monitored and controlled by the recommended program of monitoring admissions policy. The patient being admitted for surgery who receives anesthesia will still be admitted for surgery and receive anesthesia under the situation which we have described. The problem which we are concerned about in that particular case is that the CRNA who may deliver that service may have his or her employment with the hospital terminated and may have to become employed by a physician group in order to practice. The kind of problem which we cite might be effectively monitored and controlled by an appropriate peer review program although we are not concerned solely with the fact that the quality of the service provided may be substantially less. We are also concerned that the CRNA may be forced to become employed in a situation which he or she has no desire to be employed in but must accept for lack of any other method of practicing anesthesia.

When the Department of HHS submits its Prospective Payment legislation we shall appreciate the Committee paying close attention to the method which is proposed for dealing with the problem we have cited. We hope that we may be given an opportunity to comment specifically on that problem in the future when legislation is submitted and is under active consideration.

Our second concern has to do with the fact that the DHHS proposal regarding Prospective Payments seems wholly arbitrary with respect to its treatment of educational costs. Under current Medicare law, including the Section 223 limits as amended in 1982, the costs of nurse anesthetist training programs which are approved and many other forms of nursing and non-physician education, are excepted from the 223 limits upon application by the hospital. Under the current Section 223 program, the costs of intern and residency programs and some aspects of nursing education, but not nurse anesthestist training, are totally excluded from the limits and reimbursed on a cost basis. We submitted comments to HCFA on that issue recommending that all approved health education programs operated by hospitals be excluded from the Section 223 limits. To date, HCFA has not acted on our proposal. The DHHS Prospective Payment proposal exacerbates the 223 problem because it also eliminates the right of a hospital to apply for an exception for its approved educational program. The DHHS proposal permits medical education costs to be excluded and to be reimbursed on a separate basis but does not make any provision, even provisions for exceptions similar to current law, for any other forms of education offered by hospitals.

We can see no reasonable justification for this position whatsoever. Literally all of the existing nurse anesthetist training programs are operated by hospitals. There are approximately 150 of such programs. These programs are essential to the training of future nurse anesthetists.

What makes this problem with respect to educational costs particularly difficult in the field of nurse anesthesia is that there is a very severe shortage of certified registered nurse anesthetists. The Department of HEW estimates, based on studies in 1976, indicated a need during the current decade of 22,000 to 25,000 nurse anesthetists. There are currently 16,000 to 17,000 practicing. A current study which our Association has underway indicates that the shortage is probably worse than that indicated by the HEW study. The recent Institute of Medicine study published in January 1983 dealing with "Nursing and Nursing Education: Public Policies and Private Actions" indicates that the major issue of nursing shortages in this decade and through 1990 lies in the areas of nursing which demand forms of advanced nurse training. This study specifically cites clinical nursing specialties such as nurse anesthesia, nurse midwifery and nurse practitioners as areas of clinical nursing specialty which demand advanced training and are in substantial shortage situations.

Despite the substantial evidence of shortage of nurse anesthetists, we have also seen the unfortunate decrease in the number of hospitals offering nurse anesthetist training programs. The numbers of accredited programs have dropped from approximately 250 to 150 in the past 5 years. It is our opinion that these programs may drop even further if hospitals are not permitted under Medicare to be reimbursed on a cost basis for their operation. We certainly believe that nurse anesthetists undergoing postgraduate training (all nurse anesthetists having to have a nursing degree prior to going into nurse anesthetist training programs) should be treated equally with physician residents and interns under this DHHS proposal.

We would also like to bring to the attention of the Committee that nurse anesthetists are not the only professional health practitioners affected by this proposal. Other health professionals with approved training programs that have been operated by hospitals and are currently able, on an exception basis, to have costs reimbursed outside of the 223 ceiling include physical therapists, occupational therapists, medical technologists. We are attaching for the record a list of all educational programs approved for Medicare reimbursement under current law.

We hope that if you have any questions about the two issues which we have raised with regard to Prospective Payment Systems as proposed by DHHS that you will communicate with our President or with Richard Verville of White, Fine & Verville who represents our organization in Washington, D.C.

Attachment

COST OF EDUCATIONAL ACTIVITIES

(Reg. § 405.421; Principle 1-4)

[¶ 5300]

§ 405.421. (a) A provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section.

(b) *Definition—Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

(d) *"Orientation" and "on-the-job training."* The costs of "orientation" and "on-the-job training" are not within the scope of this principle but are recognized as normal operating costs in accordance with principles relating thereto.

(e) *Approved programs.* In addition to approved medical, osteopathic, dental, and podiatry internships and residency programs,[1] recognized professional and paramedical educational and training programs now being conducted by provider institutions, and their approving bodies, include the following:

Program	*Approving bodies*
(1) Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(2) Dietetic internships..	The American Dietetic Association.
(3) Hospital administration residencies.	Members of the Association of University Programs in Hospital Administration.

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[1] See § 405.116(f) of Subpart A for a listing of such approved programs. For purposes of determination of educational costs in cost reporting periods beginning prior to January 1973, podiatry internships and residency programs approved by the Council on Podiatry Education of the American Podiatry Association were eligible for approval under paragraph (f) of this section.

Program	*Approving bodies*
(4) Inhalation therapy	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(5) Medical records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(6) Medical technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(7) Nurse anesthetists	The American Association of Nurse Anesthetists.
(8) Professional nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(9) Practical nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(10) Occupational therapy.	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(11) Pharmacy residencies.	American Society of Hospital Pharmacists.
(12) Physical therapy	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(13) X-ray technology	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

(f) *Other educational programs.* There may also be other educational programs not included in the foregoing in which a provider institution is engaged. Appropriate consideration will be given by the intermediary and the Social Security Administration to the costs incurred for those activities that come within the purview of the principle when determining the allowable costs for apportionment under the health insurance program.

(g) *Calculating net cost.* (1) Except as specified in paragraph (g)(2) of this section, net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition, and from grants and donations that the donor has designated for the activities. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

(2) Effective for cost reporting periods beginning on or after January 1, 1978, grants and donations that the donor has designated for internship and residency programs in family medicine, general internal medicine, or general pediatrics are not deducted in calculating net costs.

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W. H. (Hoke) Kerns, president

Alabama Hospital Association

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March 2, 1983

The Honorable David Durenberger
Chairman, Subcommittee on Health
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senator Durenberger:

On behalf of the Alabama Hospital Association (AlaHA) and its 145 member institutions, as well as its over 550 personal members, I would respectfully request this letter be made a part of the hearing record of February 2 and 17, 1983, regarding the Medicare Prospective Payment System. AlaHA greatly appreciates the opportunity to share with you and the Subcommittee our views and comments.

AlaHA is committed to a goal of access to quality health services for all people so as to avoid a two-tiered level of care. AlaHA is greatly concerned about the escalating costs of health care in our state and nation. We have expressed our belief that the antiquated cost-based, retrospective payment system under Medicare has contributed to cost escalation. Overhauling this system of retrospective reimbursement so as to provide a framework for control of this escalation is another goal of Alabama hospitals. At the same time, we must insure that in any hospital payment methodology, rational and realistic funding for hospital services is provided for. These three related goals are the cornerstone for our comments on developing prospective payment concepts.

GENERAL COMMENTS

The Alabama Hospital Association is supportive of a prospective payment system for Medicare. We are convinced that this is the only viable option to the current cost based system. If a prospective payment system is carefully designed to shift current misplaced incentives for providers, while providing rational and realistic funding for hospital services, the problems of escalating costs and cost shifting can be brought under control. Such a system can inevitably benefit the Medicare beneficiary and private paying patient in addition to producing significant long range program savings for the government.

Affiliates
Alabama Hospital Association Trust
Alabama Health Research & Education Foundation
Alabama Diversified Health Services, Inc.
Alabama Hospital Association Credit Union

SPECIFIC COMMENTS

While there are numerous approaches as to what a prospective payment system should include, AlaHA will limit its specific comments to principles set forth in the Department of Health and Human Services plan submitted to Congress in December, 1982. Our comments so outlined may be of greater assistance in your deliberations.

HHS is to be commended for its work on this proposal. AlaHA believes that this plan is an excellent starting point for Congressional consideration. A listing of the HHS plan principles with our suggestions follows:

- Treatment of freestanding/specialty hospitals: The HHS proposal addresses this issue, and is a principle supported by AlaHA.

- Coverage of services based in general hospitals: The HHS proposal limits prospective payment coverage to inpatient acute care. This is a principle supported by AlaHA.

- Cost reports and audits: The HHS proposal inadequately addresses the cost reporting and audit burden currently existing under the retrospective system. One of the goals of the HHS proposal is a reduction in the administrative burden of the Medicare program. Hospitals should be able to share in the benefits of such reductions, so that our administrative costs can be lowered.

- Effective date: The HHS proposal calls for hospitals to come onto the system with fiscal years beginning on or after October 1, 1983. The AlaHA supports this effective date and the rolling on of hospitals fiscal years.

- Expiration date: The HHS proposal does not call for an expiration date to its proposed program. AlaHA feels that an expiration date should be included, so that an opportunity for Congressional evaluation and reauthorization of the proposal could be facilitated. AlaHA would, therefore, suggest an expiration date of October 1, 1987.

- Beneficiary liability:

  (A) Copayments and Deductibles: HHS has proposed a continuance of currently required copayments and deductibles. This is strongly supported by AlaHA. Additionally, AlaHA supports restructuring of the copayments and deductibles so as to account for when elderly patients actually require treatment and when the intensity of service occurs. Our Association feels that copayments and deductibles can be structured in such a fashion as to reduce the financial burden that is placed on the elderly and equitably recognize hospitals financial requirements. Constructing a Medicare days savings plan, which would permit the elderly to accumulate over a period of years sufficient days to meet catastrophic illness needs, has great merit.

(B) Assignment/non-assignment option: The HHS proposal makes no provision for hospitals to elect to accept Medicare assignment. AlaHA strongly opposes this restriction. Hospitals, to prevent cost shifting, must be able to bill at least a portion of the difference between government payment and service costs. If access to quality care is to be provided, and the development of a two-tiered system of care avoided, hospitals' ability to elect assignment or non-assignment must be provided for.

- Unit of price: The HHS proposal calls for a national unit of price utilizing diagnostic related groupings (DRGs) adjusted regionally for wages. Without a doubt, no other issue of the HHS proposal so sharply divides the hospital industry as does the issue of DRGs. The AlaHA is opposed to the use of DRGs as the unit of price for a prospective payment system. We do endorse the use of a national average cost-per-case unit of price that would be adjusted regionally for wage differences as well as adjusted for unusual lengths of stay on a per-case-basis. The validity of DRGs as a payment mechanism is highly questionable. Furthermore, the DRG experience in the only operational system that exists, has demonstrated its inability to realistically accommodate secondary diagnoses which result in prolonged length of stays. Strangely enough, the high cost institutions, we believe, will be protected under a national DRG approach, to the detriment of the more efficient institutions. A national average per case can be easily implemented and would protect the historically efficient institutions. High cost facilities would automatically be given an incentive to reduce costs.

- Initial year's base: The HHS proposal calls for a national average cost with an area wage adjustment to be used for determining the initial year's inpatient acute prices. AlaHA opposes this approach and recommends instead the use of individual hospital's costs. The AlaHA believes that determinations made from the base year will be crucial to the long range viability of hospitals under the system. This initial base year should come from the most recently filed Medicare cost report that has been updated through the end of the preceding fiscal year. A final base year should be determined by submission of a special Medicare cost report showing each hospital's actual cost performance, to reflect measurement of hospital input prices. The fixed price would then be adjusted to reflect the final base.

(A) Disallowed costs: In calculating the initial and final base year, the question of disallowed costs must be addressed. AlaHA, at a minimum, supports inclusion of: Hill-Burton uncompensated services treatment as bad debt; unusual malpractice costs; and unusual labor cost settlements.

- Base adjustors: The HHS proposal leaves future inflation and technology adjustments to the base year, to Secretarial discretion. AlaHA opposes this approach.

  (A) Inflation: AlaHA would support instead the use of a panel of economists, independent of government and hospitals to annually set an annual measurement of hospitals' input prices, i.e., an inflation factor. This market basket method should be legislated into a prospective payment system. This inflation factor should take into account at a minimum increases in depreciation, interest, and related financial costs.

  (B) Technology: In addition to an inflation factor, the base adjustor must include a factor that recognizes hospitals' cost increases due to advances in technology. This portion of the adjustment index must be at least the average technological cost increase for previous fiscal years or hospitals must be permitted to use purchase level depreciation for new technologically related equipment.

- Capital Costs: The HHS proposal provides a pass through for capital costs. This is support by AlaHA.

- Medical education costs: The HHS proposal provides a pass through for medical education costs. Likewise, this is a provision supported by AlaHA.

- Treatment of small rural hospitals: The HHS proposal provides for exceptions to their prospective system for sole community providers. AlaHA supports this provision but would refine it to also include an exception for small rural hospitals.

- Treatment of newly constructed hospitals and change in ownership: The HHS proposal does not address how it will treat newly constructed facilities as well as what will happen when the ownership of a facility changes. AlaHA supports the inclusion of a provision making an allowance for those hospital base years.

- Capital maintenance/return on equity factor for hospitals electing assignment: The HHS proposal does not reveal how capital maintenance will be addressed and the continuation of return on equity is unclear. AlaHA feels that both factors must be addressed for hospitals accepting assignment.

- High Medicare volume hospitals: The HHS proposal does not include any special treatment for high Medicare volume hospitals with low income patients. For the protection of these facilities under the system, AlaHA supports a special price adjustment factor for these facilities, especially those with sole community provider status.

- Exceptions and appeals: Besides an exception for sole community providers and the elimination of hospitals' access to judicial review, the HHS proposal makes no provisions for exceptions and appeals.

  (A) Exceptions: AlaHA would support the delineation as to the grounds whereby exceptions can be obtained and the criteria to be used by the Secretary in making those determinations.

  (B) Appeals: AlaHA would support the creation of an independent panel representing government, labor, business, and hospitals to act as an appeals review board, whose decisions could only be overturned by the federal courts.

- Utilization control: The HHS proposal does not address how hospitals with deemed status will be treated. AlaHA supports the inclusion of the concept of deemed status for those hospitals that have demonstrated effective utilization control programs.

- Waivers and demonstration projects: The HHS proposal makes no provision for the granting of waivers and demonstration projects. To insure that the prospective payment system is subject to review and improvement, AlaHA would support the inclusion of a provision allowing the independent review board mentioned earlier powers to grant waivers for demonstration projects. These projects reasonably would not cost the established system more and could prove beneficial to the future workability of prospective payment.

CONCLUSION

Prospective payment for hospitals is greatly needed to replace the current cost-based retrospective system. The hospitals of Alabama share your concern for the inherent problems of the present system resulting in increasingly higher medical costs, a depletion of the Hospital Insurance Trust Fund, and added strains on the federal deficit. AlaHA realizes that a move to prospective payment will not be the cure all for this country's health care problems, but it will at least provide the catalyst for much needed change. The purpose of our comments are strictly to offer our advice as to how we believe the goals of Congress on this matter, and those of hospitals in Alabama, may best be served.

Please contact me if I can provide you with further information or details on the statement.

Sincerely,

W. H. (Hoke) Kerns
President

WHK/gd

cc: Alabama Congressional Delegation

FROM: Blue Cross and Blue Shield Association
1709 New York Avenue, N.W.
Washington, D.C. 20006

CONTACT: Charlotte Crenson
(202) 783-6257

FOR IMMEDIATE RELEASE
February 17, 1983

(WASHINGTON) -- The Administration's proposal to make Medicare payments on the basis of diagnosis-related groups "is more of an outline than a definitive blueprint for payment reform," Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association told the Senate Finance health subcommittee today.

The Administration's plan has some promising features, Tresnowski said, but even without exhaustive analysis, problems are apparent. Much more study and information is needed on the impact of the proposed changes on various types of hospitals and also on hospital incentives.

"We do not believe that the proposed implementation date of October 1, 1983 is realistic," he said. Medicare intermediaries still have not implemented the Medicare payment changes adopted in legislation enacted last year for all hospitals. Also, some hospitals will not come under the new limits until September of this year.

Paying hospitals on the basis of a nationally determined average price will be more than adequate for some hospitals, Tresnowski pointed out, and will be less than adequate for others. Hospitals which may not be inefficient could be penalized and those rewarded may not be the efficient hospitals. He suggested a transition period to give hospitals a time to plan and implement constructive management changes.

"We strongly support the program continuing to hold the principle of no patient 'surcharging,'" Tresnowski stated. "We believe it is the most fundamental protection of Medicare beneficaries against otherwise uncontrollable out-of-pocket medical care costs." However, he noted that the yearly calculation of an "average" price per admission may be squeezed by Federal budgetary pressures, and may give hospitals a strong argument for billing Medicare patients for the balance of unrecovered costs.

There also would be an incentive for hospitals to reduce the average length-of-stay and intensity of services provided but profit by increasing the volume of low cost admissions, the Blue Cross and Blue Shield organization executive noted.

A major concern of the Blue Cross and Blue Shield Association, Tresnowski said,is the inherent incentive offered in the proposal to accelerate the trend toward billing patients directly for services, such as radiology, pathology, and therapy which were formerly included in the hospital bill and reimbursed by Medicare on the basis of cost.

"Hospitals and physicians can do this," he said, "by leasing space in the institution to physicians who then bill patients directly for services under Part B of Medicare. Or they may transport patients or specimens to be tested to an adjacent office building where the service will be provided to inpatients as an outpatient service and billed accordingly.

"The Medicare program could end up paying twice for services; once under the diagnostic-related group as an all-inclusive inpatient service and under Part B as an outpatient service.

"We are also concerned," Tresnowski said, "about the effect of the capital pass-through under the Administration's proposal . . . Capital expenditures today generate operating costs tomorrow." While acknowledging that the Administration may be concerned about excluding capital costs from the per case payment, he noted that hospitals can recover these new operating costs to the extent that they can increase the volume of cases.

Quality of care may be affected, Tresnowski said. Although the professional instincts of hospitals and medical staffs will go a long way toward providing protection, "tensions will arise over the limitations of price for those cases which cost the hospital more than allowed under the DRG payment." There may be incentives for insufficient care through premature discharge, inadequate testing, and other shortcuts.

"For these reasons, we believe the Congress should not rush to approve the Administration's proposal without thorough evaluation and that implementation this Fall would be precipitous."

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STATEMENT BY
ROBERT E. PATRICELLI, EXECUTIVE VICE PRESIDENT, CIGNA CORPORATION BEFORE THE SENATE FINANCE COMMITTEE, SUBCOMMITTEE ON HEALTH REGARDING HOSPITAL PROSPECTIVE PAYMENT

CIGNA Corporation is the second largest stockholder-owned insurance company in the United States, with assets of $32 billion. It is also one of the largest health insurers in the country, the largest investor-owner of health maintenance organizations with over 680,000 people enrolled, the largest investor-owned provider of rehabilitation services, and the former owner or manager of over 150 hospitals. Because of this large and diverse commitment in the health care field, CIGNA brings a unique perspective to the subject of hospital prospective payment systems.

CIGNA supports the efforts of this Committee, the Congress and the Administration to develop and encourage prospective hospital payment systems. Prospective payment has been demonstrated to be an effective way to contain hospital costs while maintaining the quality of care. Since a true prospective payment system puts hospitals "at risk" for their management decisions, widespread use of prospective payment is an essential first step in reintroducing the laws of supply and demand into the health care delivery system. CIGNA believes that over the long term, competition should and can supplement and largely replace regulation as a means of controlling the rising cost of health care.

With this objective in mind, CIGNA has developed a model prospective payment proposal with the help of experts from the hospital and insurance industries, the legal and accounting professions and the investment community. This system relies on competitive incentives to encourage the cost efficient delivery of care. In addition, it builds upon the proposed Medicare plan before this Committee and offers an integrated and long-term solution to our health care financing problems.

Before describing the CIGNA proposal, I would like to reinforce the main points made by the Health Insurance Association of America in its testimony before this Committee regarding the Department of Health and Human Services' prospective payment proposal. The Department's proposal will not accomplish its cost containment objectives because it applies only to Medicare beneficiaries. A hospital payment system must apply to all patients so that hospitals face consistent incentives from the payors of care. A Medicare-only system encourages cost accounting manipulations rather than an integrated cost containment strategy. As a result, it creates incentives to shift costs rather than contain them. Some members of the hospital community have suggested that all payor systems are equivalent to rate-setting programs. The proposal, which I will describe, clearly indicates that this need not be the case.

CIGNA also believes that the Congress should encourage the development of state-level prospective payment systems. This approach affords experimentation with innovative approaches to a complex problem and permits tailor-made solutions to regional differences. Furthermore, existing state programs have clearly demonstrated that they reduce the rate of growth in hospital expenditures for all patients, including Medicare, while maintaining the quality of care.

CIGNA PROPOSAL

The CIGNA prospective payment proposal builds upon pricing and selling practices used in most industries. While a complete description of this proposal is included in the attached appendix, the essential features of the plan are:

- Purchasers are encouraged to consider finances in the selection of care.

  Purchasers of care, including physicians, third parties and consumers, will be able to shop for hospital care by comparing prices for Diagnosis Related Groups (DRG) provided at different hospitals. The DRG price at each institution will be available to the patients and those acting in their behalf in advance of treatment.

- All usual expenses of doing business are recognized.

  Hospitals will establish their own prices for their Diagnosis Related Groups and will not be subject to rate-setting controls in a price competitive environment. They will be able to include all usual business expenses in their DRG prices. However, the basic pricing structure will normally have to be adjusted for certain hospitals that have explicit public responsibilities. Most hospitals will find that these initiatives, such as teaching and uncompensated care costs, must be financed separately from the general payment system to maintain a competitive pricing structure.

- Prices for services will be widely disclosed.

  Hospitals will have to make their DRG prices available to the public to facilitate interhospital comparisons. Hospitals will also participate in joint public/private sector utilization review programs to assure the optimal use of resources and the provision of quality care.

- Discrimination in prices is avoided.

  While hospitals will be required to avoid discriminatory pricing practices, negotiation of special prices reflecting payor practices that result in savings to the hospital for their patients will be allowed. Therefore, not all payors will pay the same price. Criteria for special pricing considerations may be developed by each hospital, but must be equally available to all payors.

- All patients are included.

  The payment system will be applicable to all patients, irrespective of the source of payment or insurance coverage, with special consideration for patients not included in third-party payment groups.

- Profit and loss or the retention of surplus are permitted.

  The payment system will make hospitals financially responsible for their decisions by allowing profitable hospitals to retain surpluses and for others to incur losses, regardless of tax status.

- Effective accounting, auditing and reporting practices are used.

  The payment system must minimize accounting, auditing and reporting requirements. Hospital financial reports must contain sufficient information to allow payors to compare hospital performance.

- Implementation is phased-in.

  The payment system must be phased-in to allow adequate time for appropriate participation by patients, providers and payors.

- State programs are encouraged.

  The Congress should provide incentives for states to experiment with competitive pricing systems. This experimentation will allow prospective payment systems to meet the special needs of each state and to refine the competitive pricing approach.

ESTABLISHING THE NEW PAYMENT SYSTEM

The proposed payment system described above requires meaningful change by all participants in the health care field, including hospitals, practitioners, patients and insurers. In some instances, legislative initiatives will be needed to accomplish these changes. Some of the legislative provisions include:

- Establishing incentives for states to develop all-patient prospective payment systems;
- Disclosing by hospitals of DRG-specific price and utilization data for all patients;
- Requiring cost sharing in health insurance plans;
- Creating a special means to finance teaching and uncompensated care costs; and
- Prohibiting unfair discrimination in hospital prices.

We believe that the Medicare prospective payment legislation can and should anticipate longer term reform of the entire payment system. A proposed approach and timetable is set forth on pages 7-8 of our attached proposal. We would be pleased to work with you and your Committee to develop specific legislative language to incorporate some or all of our suggestions into the current legislation.

SUMMARY

The payment system described here would be created by a minimum of regulation and would allow hospitals to operate more like other economic enterprises. It includes basic marketplace procedures and incentives to encourage efficient use of health care resources. It requires gradual but substantial procedural and behavioral changes of all health care participants who must work together to assure that quality care will be provided at an appropriate cost.

This payment system offers advantages to all participants in the health care field. Hospitals and physicians will operate in a system that includes marketplace principles and avoids onerous regulation. Providers will have incentives to consider productivity and resource usage in the provision of care. They will also be able to predict revenues because prices for care would be determined prospectively. Likewise, third-party payors, including government, will be able to examine the prices paid for care on the basis of common and objective data, recommend efficient providers and predict their costs accurately. Third-party payors could evaluate the performance of institutions and providers and adjust their practices to encourage further efficiency. Consumers and those acting in their behalf will be able to make informed choices about the selection of care and will know their payment liability in advance of treatment. Finally, the system will assure the provision of quality care at competitive prices to all public and private sector patients.

D

A COMPETITIVE PRICING SYSTEM FOR HOSPITAL PAYMENT

I. Introduction

The 97th Congress recently enacted legislation to stringently regulate Medicare payments to hospitals. In addition, they mandated the Department of Health and Human Services to establish a system of prospective reimbursement for Medicare. DHHS has responded by proposing a Diagnosis Related Group (DRG) system which will establish national payment rates. Clearly, the direction is toward an increase in federal regulation of hospital pricing.

Many people believe that over the longer term, competition should supplement regulation in controlling health care spending. In a competitive pricing system, as described here, hospitals identify their products in a comparable fashion, establish their own price for products in advance, and make both product descriptions and prices available to consumers. Patients, physicians, or third party payors acting in their behalf could then shop for care on the basis of price, as well as quality and other consumer preferences. The payment system emphasizes adequate communication of information to assure competitive pricing. An essential element of this system is that the product must be similarly defined across institutions, so consumers have a basis for comparison. Continuing regulation will be required to accomplish this. This system will eliminate the duplicative and costly multiple accounting, audit and review procedures that are presently used because a total hospital product will be compared rather than the individual components such as lab tests, nursing care, room and board. Further efficiencies will be obtained because one system can be applied to all public and private third party payors.

An essential ingredient of this system is that it places the hospitals at economic risk for their business decisions. This prospective system allows for profit or surplus to be accumulated, but does not give institutions assurances of financial solvency. Hospitals would be paid according to their preestablished prices for fixed periods of time and operate within the revenues generated by these prices.

While this system places hospitals at financial risk for their business decisions, it recognizes that certain hospitals also have social responsibilities to deliver charity care, and to perform teaching and research. The costs associated with meeting these public policy objectives could make certain institutions uncompetitive or even financially insolvent. Thus, our system contains safeguards to assure that these costs are covered outside normal payment practices. The system could be used nationally but might be better implemented initially at a state or regional level as long as all patients participated.

II. General Principles of the Payment System

Nine general principles are embodied in this proposed payment system for hospital care. They are as follows:

A. Purchasers are encouraged to consider finances in the selection of care.

B. Prices for services will be widely disclosed.

C. All usual expenses of doing business are recognized.

D. Discrimination in prices is avoided.

E. All patients are included.

F. Profit and loss or the retention of surplus are permitted.

G. Practices and services designed to meet social objectives desired by the community at large are clearly identified.

H. Effective accounting, auditing, and reporting practices are utilized.

I. Implementation is gradual.

III. Description of the Hospital Product

In this new system, hospitals will establish prices for a given case on the basis of Diagnosis Related Group (DRG). The DRG must, over time, be further refined to more accurately reflect the resources consumed for the treatment of an individual case or discharge. If possible, they should be expanded to cover certain outpatient procedures as well. Hospitals will define their product uniformly but they will be free to decide what to include in the price.

Developing meaningful DRGs will not be easy and the initial effort will not be perfect. Nevertheless, much of the research and development of systems which use DRGs has already taken place. A more refined system is well within the limits of existing knowledge and data collection capabilities of the hospital industry. However, hospitals must be allowed time to create an accurate data base for efficient system operation.

Special Circumstances

The DRG payment system bases price on usual resource consumption and implicitly relies on the statistical "law of averages" to assure that payment is equitable. Thus, on the average, the price paid for care consumed is closely related to the hospital's cost to provide care. This system is equitable for payors who represent large groups because cost variations will average out over a large population. However, the system can result in inequitable prices for an individual patient who pays his own bill. His actual use of service could be significantly different from the average for the DRG. Thus, a separate pricing approach must be devised for the relatively few patients who pay their own bills. Fee-for-service type pricing would be adequate for this group.

IV. Description of Payment Methodology

This methodology was developed to encourage price competition but gives hospitals with diverse objectives an equal opportunity to attract patients.

A. Setting Hospital Prices

In the proposed payment system, hospitals will customarily include all normal business expenses in their pricing structure for a "DRG". Although standard product definitions will be presented in the form of DRGs, prices will be set solely by hospitals. Competitive marketplace incentives, influence from consumers and third party payors, and existing antitrust laws will ultimately provide protection against unreasonable and unnecessary price increases in an entire community.

Some hospitals might not have a competitive pricing structure because they have certain expenses, such as medical education, charity care, research and special community services that represent community responsibilities. Provisions must exist so that no hospital is placed in an uncompetitive position solely because it provides services that the community considers socially desirable. These expenses could be included in the DRG price if a hospital desires, but more likely, they will be excluded. They should be identified on the financial statements for the information of the consumer and public recognition of the special role of certain hospitals.

B. Uncompensated Care Costs

Uncompensated care costs are incurred by those who do not pay their hospital bills and includes both bad debt and charity care costs. In most industries, bad debt is a normal business expense and it would be reasonable to treat hospital expenses in the same manner if the distinction between bad debt and charity care expenses could be made. However, hospitals have found it administratively easier and less expensive to not try in advance to establish whether patients have the resources to meet all of their financial obligations. Therefore, much of what is classified as bad debt would be considered charity care under a more precise definition of terms.

Despite the current lack of clarity in distinguishing between bad debt and charity care, the costs of charity care incurred both on an inpatient and outpatient basis should be excluded from the DRG price because it is a public responsibility. State or local political bodies could determine the level and type of financing for this care. Three approaches are possible: 1) general state-city revenues derived from income or property taxes; 2) special hospital district taxes such as those now used for fire districts, school districts, park districts and the like; and 3) a surcharge on all inpatient care at all hospitals in a given region which would be accumulated in a special fund and used to subsidize institutions with high indigent patients loads. The third approach has recently been enacted into law in both Massachusetts and New York state, and it appears to be a reasonable alternative, but others merit consideration.

C. Teaching Costs

There are two types of expenses incurred by teaching hospitals which could make them non-competitive in price.

1. Direct teaching expenses that can be estimated from hospital accounting data such as salaries, supplies and teaching space.

2. Indirect education costs that are incurred by teaching hospitals such as productivity losses, extra ancillary services and the like.

The direct costs of educational programs provided in teaching hospitals was estimated at approximately $2 billion in 1980. These costs should be excluded from the DRG price so that teaching hospitals can maintain a competitive pricing structure.

The indirect costs of educational programs provided in teaching hospitals was estimated at approximately $4 billion in 1980. These costs may partially reflect a more severely ill case-mix treated at teaching hospitals and the need for more highly skilled resources. These costs may also reflect the high quality of care that is provided at these tertiary institutions. At least some of these costs are related to patient care and perhaps should be included in the DRG price.

The appropriate method and level of financing for teaching services must be addressed to maintain the integrity of our teaching facilities. These costs may be financed through a national educational trust, state subsidies, a surcharge on admissions, increases in tuition costs, special taxes, or other methods. We must decide if the level of special funding should include only direct medical education costs or indirect costs as well. Without satisfactory answers to these difficult questions a competition pricing system will be difficult to achieve.

D. Research Costs

The costs of sponsored research will probably be excluded from the DRG price and will continue to be financed by the sponsoring agency. Unsponsored research is generally not so large that it could not be included in the DRG price according to each hospital's guidelines as it seeks to maintain a competitive pricing structure.

E. Special Community Programs Costs

Services provided for special community programs, such as a family planning or blood pressure detection plans may be excluded from the price for a DRG. Most hospitals may want to make these programs self-supporting through fees charged to program participants. They could also be financed through a special state or local fund or specific private donations.

F. Capital Costs

A competitive pricing system will allow hospitals to accumulate surplus for the purchase and maintenance of plant and equipment. Therefore, there is no need for special treatment of capital and it should be included in the DRG price.

G. Hospital Prices to Particular Payors

Hospitals should not unfairly discriminate in the prices charged to different patients since this inhibits competition in the financing mechanisms. Individuals or third-party payors should continue to negotiate special prices, but an anti-discrimination provision would strengthen the ability of the hospitals to deal with large payors as well as protecting smaller payors. The payment criteria developed by the hospital will have to be applied fairly to all payors at that hospital and should reflect payor practices that save the hospital money.

V. Special Circumstances - Sole Community Providers

The number of areas served by sole community providers and the populations residing in these areas is relatively small. The National Center for Health Statistics estimates that only 125 out of a total 720 discrete medical service areas have only one hospital. Likewise, there are 127 medical service areas that have only two hospitals. Thus, 16 percent of the hospitals are sole community providers, but these institutions serve only 3.1 million people or 1.2 percent of the U. S. population. Only 9 million people or 3.4 percent of the total population are served in areas with two hospitals. Hence, most patients are served in areas where a system of hospital price competition can become a reality.

The price competitive system described in this testimony should apply to all hospitals - even sole community providers. It may be necessary for consumers and third-party payors to carefully evaluate the experience of sole community providers and apply pressure more actively to assure equitable pricing practices. While special price controls could be developed for sole community providers, the small number of people affected suggest that this is unnecessary. Incidentally, the same principles apply and the same solutions suggested in situations where only one hospital in an area provides a very specialized service.

VI. Financial Reporting

The methodology described does not require the development of a uniform cost accounting and report system. Costs become the internal concern of hospital management and only prices are the concern of third party payors and consumers. Hospitals will, however, be required to use a uniform description of their "products" to facilitate price comparison. Many hospitals will develop a more sophisticated cost accounting system than is commonly in use today. However, the accounting system need not be universal and uniform, rather it should be designed to meet the management and internal auditing requirements of the individual hospital.

Hospitals which seek special funding for social services functions, such as educational expenses or charity care, will have to document the amount for which they qualify. Hospitals should also publish a supplement to their financial statements which allows analysis of the income and disbursements related to providing the special social services, uncompensated care, teaching and research described above. Interim government guidelines may be necessary but, as quickly as possible, two supplemental schedules to Generally Accepted Accounting Principles (GAAP) would be created for hospital financial reporting (see Schedules A and B). The new guidelines would be developed by American Institute of Certified Public Accountants to accomplish three things:

- Define the nature of usual expenses reported in the DRG price and the supplemental activities;

- Outline requirements relating to revenues and disbursements including a description of how these items should be identified on the hospital financial statement; and

- Define the format and content of a hospital's annual statement to include aggregate financial data, supplementary information on social services, and price and utilization data by payor. To allow proper evaluation and comparison, historical data as well as current year figures would be available.

VII. Payment of Claims

Claims payment and review will be greatly enhanced with the widespread use of the Uniform bill. As DRG becomes the predominant method of payment, the data required for the payment of a claim will be substantially reduced because only patient identifying data, a price and a DRG number will be required. Of course, hospitals and payors would be free to negotiate a variety of payment procedures.

VIII. Auditing and Review Requirements

A major objective of this system is to minimize the need for regulation of providers and for individual claim and hospital audits. Under the proposed system there would be a number of safeguards for patients, the general public and payors. First, the hospital would publish audited financial reports, like other businesses, that include simple utilization and price data by payor. This would allow identification of changing utilization and price patterns. Second, existing hospital utilization review programs will undoubtedly continue to be developed and refined. Business coalitions and individual employers are insisting on better data to justify costs. In addition to monitoring quality of care, this would allow easier identification of cases where inappropriate utilization of services occurred. Third, any payor who felt discriminated against in the prices charged to its patients would be able, through the courts, to subpoena hospital records.

In summary, public disclosure of prices and special expenses will allow normal marketplace scrutiny of hospital activity. Since public disclosure of prices is an important part of this audit mechanism, hospitals must be required to publish prices and give public notice of intent to change prices.

IX. Establishing the New Payment System

It is critical that Medicare, as the largest payor, assume a responsible leadership role. It must address the issue of rising health care costs as a national problem not just as a Medicare problem, and assure that interim changes in Medicare reimbursement are consistent with a competitive pricing environment. The payment system discussed in this paper requires changes by all health care participants -hospitals, practitioners, insurers and consumers. In certain instances, legislative and regulatory initiatives will be needed to accomplish these changes.

Legislative Changes

Legislative changes to create the long range system could be accomplished over a five year period. The following legislation is proposed:

Year 1: 1. Establish a Medicare DRG system. Allow Medicare to establish rates for the first three years to accommodate current budget restrictions and to allow full development of the competitive mechanisms.

2. Require hospitals to maintain and disclose costs and utilization statistics by DRG for ALL payors. This would be a condition of participation in Medicare and allow an immediate increase in cost containment activity by private payors.

3. Create incentives for states to develop ALL payor prospective payment systems, e.g.,

   a. Increase Medicaid matching funds for state with system that meet target rate of revenue increase.

   b. Include DRG start up costs in hospital reimbursement rates.

   c. Provide federal funding for medical education as long as target revenue increase rates are met.

   d. Provide states with start up money to develop the state's program.

Year 2: 1. Require cost sharing options for both Medicare and private health plans.

Year 3: 1. Create a national or state medical education trust fund or develop other solutions to fund medical education.

2. Require states to develop statewide program for funding uncompensated care; reduce Medicaid matching fund for states not complying.

3. Provide for the creation of state pools for uninsurable and high risk individuals and groups to reduce the incidence of uncompensated care.

Year 4: 1. Enact legislation prohibiting unfair discrimination in hospital prices. Non-discrimination would be a condition of Medicare participation.

Year 5: 1. Require all hospitals to use prospective pricing by DRG for all payors. This would be the national residual program only for those states that have not enacted state programs.

X. Probable Response By Health System Participants

A. Physician Response

The argument is frequently raised that utilization and cost decisions are out of the hands of the consumer and third party payors. These decisions are made by the physician and stronger controls on physician prices are required. The DRG system proposed, by definition, will introduce a new dimension of cost consciousness into physician practices. It creates incentives to limit ancillary services and lengths of stay. The internal accounting mechanisms that hospitals will develop to manage more effectively will also help hospital administrators to influence physician practices more directly. When accompanied by effective utilization review, physicians have and will continue to positively respond to factual presentations of how their practices impact cost. Any instantaneous response is not to be expected but physician practice patterns will change as educational efforts increase and comparative information develops.

B. Third Party Payor Response

The movement toward inclusion of more cost sharing in health benefit plans has already begun in the private sector. The disclosure of price information inherent in this payment system will greatly enhance the development of Preferred Provider Plans. Differing levels of payments or reduced cost sharing at lower cost institutions will become more prevalent in most insurance programs. The development of plans that pay fixed rates are likely to reappear.

C. Hospital Response

The response from the hospital industry is likely to be varied and will probably be related to their current practices, financial situation, and the population they serve. In the longterm, this prospective pricing proposal will result in a more cost efficient delivery of quality services. Hospitals will more directly compete for patients and have greater responsibility for the behavior of their attending physicians. However, as the system is being implemented, it is essential that hospitals be given sufficent time and resources to make the necessary changes to prevent undue hardships for both hospitals and consumers.

D. Consumer Response

Most consumers currently have insurance coverage that protects them from the full financial burden of their health care decisions. As insurance policies include more hospital cost sharing features and preferred provider options, consumers will become more cost conscious in the selection and use of services. In most instances, however, the physician and insurer will still assume a major role in the selection of services. Some consumers will directly respond to the financial incentives in the system, but this requires the widespread availability of price and quality information.

XI. Summary

The payment system described would be created by a minimum of legislation and would allow hospitals to operate more like other economic enterprises. It includes basic marketplace procedures and incentives to encourage efficient use of health care resources. It requires gradual but substantial procedural and behavioral changes of all health care participants who must work together to assure that quality care will be provided at an appropriate cost.

As legislation is developed to move Medicare to a prospective payment system, we would strongly urge the Committee to consider the longer term needs of all consumers and the impact of the legislation on the private sector financing mechanisms. We believe that the principles outlined in this testimony form a good basis for the development of truly responsible legislation.

C.A.R.E.
Continental Association of Resolute Employers
GOVERNMENT AFFAIRS OFFICE

MR. CHAIRMAN, AND MEMBERS OF THE COMMITTEE. MY NAME IS KEVIN ROWLAND. I REPRESENT C.A.R.E., THE CONTINENTAL ASSOCIATION OF RESOLUTE EMPLOYERS, A NATIONAL SMALL BUSINESS SERVICE ASSOCIATION WHICH SERVES THE NEEDS OF OUR 70,000 MEMBERS.

MY ORGANIZATION'S CONCERN REGARDING THE PROPOSED MEDICARE PROSPECTIVE PAYMENT SYSTEM STEMS FROM THE INFLATIONARY SITUATION NOW UNIQUE TO HEALTH CARE AND AFFECTING OUR NATION'S HEALTH CARE DELIVERY SYSTEM. IN 1982 HEALTH CARE COSTS ROSE 12.6%, THIS IS MORE THAN THREE TIMES THE OVERALL INFLATION RATE OF 3.9%. OUR MEMBERSHIP, MOSTLY SMALL BUSINESS EMPLOYERS AND EMPLOYEES ARE FINDING DOUBLE DIGIT INFLATIONARY INCREASES IN THEIR HEALTH INSURANCE PREMIUMS TO BE OVERWHELMING.

ACCORDING TO THE UNITED STATES CHAMBER OF COMMERCE EMPLOYEE BENEFITS SURVEY, 60% OF THE INFLATIONARY COSTS ARE BEING CARRIED BY SMALL BUSINESS. IN LIGHT OF THE ECONOMIC PROBLEMS FACING SMALL BUSINESS AND THE RISING COSTS OF HEALTH COVERAGE, C.A.R.E. FINDS THAT MANY SMALL BUSINESS OPERATORS ARE CANCELLING THEIR HEALTH INSURANCE. THE IMPACT OF THIS SITUATION IS DRAMITIZED IN A RECENT EVENT. A C.A.R.E. MEMBER WAS FORCED TO CANCEL HIS COMPANY'S HEALTH COVERAGE DUE TO HIS ECONOMIC PROBLEMS AND A STEEP PREMIUM INCREASE FOR 1982. THIS MAN WAS KILLED THIS PAST MONTH IN AN AUTO ACCIDENT. HIS WIFE SUFFERED INJURIES, AND ADVISES C.A.R.E. THAT SHE IS NOW FACED WITH AN OVERWHELMING $30,000 IN HOSPITAL BILLS. THE MAJORITY OF THE PREMIUM INCREASE

IS DUE TO COST SHIFTING. UNLESS COST SHIFTING IS STOPPED, WE WILL SEE AN INCREASE IN SUCH SITUATIONS.

IT IS ESTIMATED THAT 6 BILLION DOLLARS OF THE HEALTH CARE PREMIUM INCREASE IS DUE TO THE COST SHIFTING CREATED BY THE CURRENTLY INADEQUATE MEDICARE REIMBURSEMENT SYSTEM. BECAUSE THE MEDICARE PAYMENT SYSTEM DOES NOT REIMBURSE HOSPITALS FOR THE TOTAL EXPENSES INCURRED, THESE FINANCIAL LOSSES ARE CHARGED TO THE PRIVATE PAYOR IN THE FORM OF HIGHER HEALTH CARE COSTS WHICH ARE REFLECTED IN CORRESPONDINGLY HIGHER PREMIUMS FOR HEALTH INSURANCE. WITH A REVISED MEDICARE REIMBURSEMENT SYSTEM, USING HHS'S PROPOSED PROSPECTIVE PAYMENT SYSTEM AS A BASE, THIS NATION'S HEALTH CARE DELIVERY SYSTEM COULD BECOME MORE EQUITABLE AND THEREFORE AFFORDABLE FOR SMALL BUSINESS.

AS THE PROSPECTIVE PAYMENT SYSTEM IS DEVELOPED, THE FOLLOWING PRINCIPLES SHOULD BE APPLIED TO INSURE THE SYSTEM WILL BE EQUITABLE TO ALL PAYORS WHICH WILL PARTICULARLY BE BENEFICIAL TO 37 MILLION AMERICANS EMPLOYED BY SMALL BUSINESS. THESE PRINCIPLES INCLUDE:

1) CONSISTENT FINANCIAL INCENTIVES FOR ALL PARTICIPANTS TO CONTROL THE GROWTH OF HEALTH CARE SPENDING OVER THE LONG-TERM.
2) THE NEEDS OF ALL PARTICIPANTS IN HEALTH CARE (USERS, PROVIDERS AND THE GOVERNMENT) MUST BE BALANCED.
3) THE FINANCIAL INTERESTS FOR ALL PARTIES INVOLVED

MUST BE BALANCED.

4) USERS CHOICE OF AND ACCESS TO QUALITY HEALTH CARE MUST BE CREATED THROUGH INCENTIVES AND ADEQUATE PAYMENT TO THE PROVIDERS.

WE RECOMMEND THAT THE CONTINUATION OF WAIVERS FOR MEDICARE ALTERNATIVE PAYMENT SYSTEMS SUCH AS FOUND IN MARYLAND AND NEW JERSEY, SHOULD BE CONTINUED AND ENCOURAGED. ONLY THROUGH INNOVATION CAN THE ENTIRE MEDICARE PROGRAM EVOLVE AND ADAPT TO THE CHANGING CONDITIONS IN THE HEALTH CARE MARKETPLACE.

THE ADOPTED MEDICARE PAYMENT SYSTEM SHOULD ALSO PROVIDE AND ENCOURAGE THE CONTINUATION OF CONTRACTING FOR SERVICES ON A CAPITATION BASIS, A PRE-PAID HEALTH CARE SYSTEM. BY USING THIS COST SAVING ALTERNATIVE, THE FEDERAL GOVERNMENT WOULD TAKE ADVANTAGE OF THE SUCCESSFUL HEALTH MAINTAINANCE ORGANIZATIONS WHICH TODAY PROVIDE QUALITY, LOW-COST CARE TO MILLIONS. THIS PROCEDURE SHOULD SUBSTANTIALLY REDUCE THE COST SHIFTING PROBLEM THAT IS NOW IMPACTING SO HEAVILY ON THOSE WHO RELY ON PRIVATE INSURANCE COVERAGE AND THEY ARE PRIMARILY EMPLOYED BY SMALL BUSINESS.

IN ADDITION, INCOME TESTING WOULD PROVIDE A SLIDING SCHEDULE FOR CO-PAYMENTS AND DEDUCTIBLES BASED ON THE BENEFICIARY'S INCOME. THIS CONCEPT IS SIMILIAR TO THE PROPOSED SOCIAL SECURITY BENEFIT TAX WHICH IS INCLUDED IN THE SOCIAL SECURITY REFORM LEGISLATION CURRENTLY BEING CONSIDERED BY CONGRESS.

UNDER AN INCOME TEST FUTURE BILLIONS COULD BE CUT FROM MEDICARE PAYMENTS. THIS EFFECT WOULD BE ANOTHER REDUCTION IN COST SHIFTING.

MR. CHAIRMAN, C.A.R.E. RECOMMENDS THAT A PROSPECTIVE PAYMENT SYSTEM BE ENACTED. THE CURRENT SYSTEM WILL ONLY ALLOW THE CONTINUANCE OF COST SHIFTING AND THE IMAPCT WHICH SMALL BUSINESS EMPLOYERS AND EMPLOYEES CAN NO LONGER SUFFER.

IT IS THROUGH ADOPTION OF A PROSPECTIVE PAYMENT SYSTEM CONGRESS WILL BE TAKING THE FIRST STEP TOWARD HEALING OUR HEALTH CARE DELIVERY SYSTEM. CONGRESS SHOULD CONTINUE TO ADDRESS HEALTH POLICY ISSUES WHICH SPUR MARKETPLACE COMPETITION AND RESTRAIN THE OVER UTILIZATION OF OUR HEALTH CARE SYSTEM.

THE CONTINENTAL ASSOCIATION OF RESOLUTE EMPLOYERS IS PREPARED TO WORK WITH CONGRESS AND THE ADMINISTRATION TO DEVELOP AN EQUITABLE AND ACCEPTABLE HEALTH CARE DELIVERY SYSTEM.

STATEMENT OF THE
HOSPITAL ASSOCIATION OF NEW YORK STATE

The Hospital Association of New York State (HANYS) represents 350 voluntary and public hospitals and residential health care facilities.

Our Association has long advocated the establishment of a prospective payment system for Medicare. We believe such a system would promote economic efficiency, stability and long range planning within the hospital sector.

Following three years of development, and with the approval of the Secretary of Health and Human Services through the granting of a Medicare waiver, New York's Prospective Hospital Reimbursement Methodology (NYPHRM) - a restructured inpatient financing system - was implemented in New York State for the period January 1, 1983 to December 31, 1985. NYPHRM represents the most profound change for the health care industry of our State since the Cost Control Act of 1969, which resulted in the development of the reimbursement system as we now know it. It also represents the culmination of efforts by interested parties to create a stable hospital financing system for the State of New York. While we do not necessarily believe that our system should be a model for national implementation, we believe that a general overview of NYPHRM, and the prior experiences which led to it, would be beneficial to the Committee as it continues its deliberations on the issue at hand.

GENERAL OVERVIEW

Prior to NYPHRM, hospitals within New York State had been paid for inpatient services under several different reimbursement methodologies.

For payment of services provided to Medicare beneficiaries, the federal government used a retrospective reimbursement methodology where hospital reimbursement was determined on the basis of services already provided. Rates paid by Blue Cross, Medicaid, Worker's Compensation and No-Fault Insurance were calculated under differing prospective reimbursement systems where hospital rates were set before services were provided based on the hospital's historical cost experience adjusted for inflation. Under the new system, hospitals will be reimbursed for inpatient services provided by all payors on the basis of a uniform State developed prospective reimbursement system. In 1984 and 1985 all payors are affected by the system through the computation of a prospective inpatient revenue cap which places an overall limitation on hospital inpatient revenues. Once prospectively established, the revenue cap may be adjusted only to reflect major changes in volume, service intensity, expansion and operations. For hospitals this new methodology will mean stable and predictable finances for the first time in 15 years.

At the same time, under the new system, all payors will participate in the financing of at least part of the costs hospitals incur through bad debts and charity care. Payors will also provide an allowance to aid financially distressed hospitals.

BASIC PRINCIPLES

Uniform Prospective Methodology

Hospitals' reimbursement rates from major third party payors will be set under a uniform prospective system. This will help eliminate the conflict caused by differing reimbursement procedures and enable hospitals to project, with a greater degree of certainty, their revenues during 1984 and 1985.

Revenue Cap

Reimbursement to hospitals under NYPHRM will be based on the same fundamental concepts throughout the three years of the program. 1983 rates for hospitals will be calculated using each facility's 1981 allowable costs trended forward for inflation. Hospital revenues for 1984 and 1985 will use revenues set in 1983 (still based essentially on 1981 costs) trended forward for inflation and adjusted for the "phase-in" components of the new system. The revenue cap will be adjusted only to accommodate major changes in case mix, expansion, volume or other cost influencing changes in operations. An independent panel of economists will determine the inflation factor to be applied from 1981 to 1983, as well as in 1984 and 1985.

Bad Debt and Charity Care Allowance

A significant feature of NYPHRM is a methodology developed to provide revenues to hospitals for costs incurred in providing care to the poor and uninusred. Under NYPHRM, funds are created in regional pools for distribution to hospitals on the basis of hospital-specific need. All payors will participate proportionately in the creation of the pools, with the size of each regional pool determined by regional need. Throughout the State, the total bad debt and charity care allowance to be available is 2% of total statewide reimbursable costs in 1983, 3% in 1984 and 4% in 1985. Those funds in each regional pool will be distributed only within that region.

Discretionary Allowance

Each facility will receive a 1% discretionary allowance added to its reimbursement rate each year to retire short term debt, to further offset bad debt and charity care, or to be used for any other purpose, at the discretion of the facility's governing board. Additional monies under this allowance will be available to hospitals subject to criteria to be established regarding the utilization of the monies.

Financially Distressed Hospital Pools

Regional pools to aid financially distressed hospitals will equal 1/3 of 1% of each voluntary and proprietary hospital's reimbursement rate. Access to these pools is limited to voluntary and proprietary hospitals lacking the resources to continue caring for the medically indigent. Guidelines governing access to these monies will be established by the New York State Hospital Review and Planning Council.

Transitional Funds

Regional transitional funds will equal 1/4 of 1% of each voluntary and proprietary hospital's reimbursement rates to aid those facilities that are negativey impacted by the implementation of NYPHRM. Guidelines to govern the distribution of these monies will also be established by the New York State Hospital Review and Planning Council.

Administration

The New York State Hospital Review and Planning Council and the Office of Health Systems Management (OHSM) will continue to function in their established roles. The Council will be responsible for adopting reimbursement regulations subject to the approval of the Commissioner. OHSM will be responsible for the computation of hospital revenue caps based on the State enabling legislation and the regulations under NYPHRM. Once these revenue caps are established, OHSM will calculate Medicaid rates, Blue Cross will calculate Blue Cross rates, and federal fiscal intermediaries will figure Medicare rates. The Council on Health Care Financing, a legislatively created body, and the New York State Senate and Assembly Committees on Health will actively monitor remaining regulations necesary to implement NYPHRM.

Although not a panacea, NYPHRM offers significant improvements over previous systems. While some hospitals may find revenues reduced, most will receive greater income, and the industry as a whole will benefit financially. Facilities currently close to bankruptcy will most certainly be helped.

One of the conditions of federal approval of our new system was that hospital Medicare expenditures in New York State be kept 1.5% below the rate of national increase. We believe this to be an arbitrary cap which essentially provides a disincentive for states to cooperatively work with their hospital sectors to develop new and innovative uniform payment systems which will be beneficial to the federal government, as well as the public. In addition, such a requirement ignores past savings accrued by the federal government as a result of the cost containment initiatives taken in our State since 1969. While we shall attempt to meet that requirement, and indeed our rate of growth has been far below the national average for several years, the need to rebuild the infrastructure of our system after years of deterioration will make it difficult. We believe that a similar limitation should not be imposed in the event that our system is extended beyond its December 31, 1985 expiration date.

NATIONAL PROSPECTIVE PAYMENT

The Secretary of Health and Human Services (HHS) has proposed that Medicare prospective payment be based on a diagnostic related group (DRG) method. While we will not be immediately affected by this proposal, we do wish to express the general concern that DRGs as a unit of payment is being proposed on a nationwide basis in the absence of adequate experimentation. We believe that states which currently have waivers to implement a non-DRG based system should be encouraged to continue their experimentation, and that other states, with the cooperation of their hospital sectors, be encouraged to pursue waivers to implement systems which may or may not be based on DRGs.

Should the Congress decide to pursue the HHS proposal, or any other prospective payment plan, we believe that the following principles should be included:

- Rates of payment should be hospital specific, as is the case in New York, and not be based on a national average which would unduly penalize certain areas of the country and provide a financial windfall to others.

The argument that hospital specific rates would reward past inefficiencies is not valid for states - such as New York - which have had extensive experience with cost containment which has removed the fat from the system, and, in some cases jeopardized its viability. In other cases, appropriate adjustments can be made. At the very least regionally (i.e., SMSAs) based rates should be a part of the system.

- Rates should be adjusted on a regularly scheduled basis to reflect inflation and new technology costs, as well as other factors, based on the most recently available cost reporting data. Such adjustments should be by a panel independent of HHS (such as the Independent Panel of Economists used under New York's system) which is capable of making an objective judgement.

- While the NYPHRM system has, in general, resulted in a more equitable reimbursement system in New York, there is one major problem which may foreshadow a similar one at the national level. The conversion from a retrospective system for Medicare to a prospective one adversley affected a small number of hospitals. The Transition Fund previously described may not be adequate to correct the hurt incurred by the conversion, since the hospitals affected have a very high Medicare patient occupancy (overall New York is about 45%). The conversion from a retrospective Medicare system to a prospective one on the national level may produce a similar situation. Provisions must be made to preclude such intense hurt.

- A strong appeals mechanism needs to be built into the system to provide hospitals the ability to seek adjustments when it can be demonstrated that a promulgated rate is inappropriate for its individual circumstance. The bases for appeals should include one related to hurt caused by conversion to the prospective Medicare system. In addition, the system should not preclude access to the federal courts to adjudicate disputes over the system and obtain relief.

- We believe the system should provide for a "pass-through" of capital and teaching costs. These are issues which are of extreme importance to our State in particular.

- The system should provide for an aggressive Medicare prospective payment waiver program under which a group of hospitals, or a state that has the support of the affected hospitals, can establish an alternative Medicare payment system. Waiver requests should be based on (a) a reasonable assurance that the applicant's proposal will result in total Medicare payments during the waiver period no greater than those anticipated under the federal Medicare prospective payment system; or (b) the proposal offers a significant opportunity to advance the state of knowledge concerning hospital prospective payment.

- The system should be complemented by a health planning and peer review mechanism designed to assure quality control and appropriate utilization. Our Association supported enactment of the peer review provisions contained in the Tax Equity and Fiscal Responsibility Act of 1982. We are distressed to see that the President has proposed no funding for PSROs/PROs in FY 1984 and urge that the Congress rectify the situation. Additionally, we support deemed status for those hospitals which can demonstrate an ability to conduct utilization review.

In the area of health planning, we strongly beleive that federal financial support must be continued, but that states be given the flexibility for the development of their own systems.

CONCLUSION

We believe that Congress should enact a prospective payment plan for Medicare this year which includes the principles outlined above. At the same time, it must be noted that we are a geographically expansive nation with diverse regions. The ability of states to experiment with other payment mechanisms must be maintained, and even encouraged. It is only through such experimentation that we can finally develop a fair and equitible payment system, which may differ from region to region, but which will ultimately be in the best interests of the public we all seek to serve.

IHC HOSPITALS, INC.
A COMMUNITY HOSPITAL SYSTEM SERVING THE INTERMOUNTAIN WEST

36 South State Street, 22nd Floor, Salt Lake City, Utah 84111, 801-533-8282

INTRODUCTION

This statement is submitted on behalf of IHC Hospitals, Inc., one of five health care related corporations of Intermountain Health Care, Inc., a not-for-profit parent corporation, with corporate offices in Salt Lake City, Utah. IHC Hospitals is a not-for-profit corporation which owns, leases, or manages 23 hospitals with a total of 2,898 beds and several outreach clinics in the Rocky Mountain area. IHC Hospitals, Inc. is a member of the American Hospital Association and the Associated Hospital Systems. We are pleased to offer this testimony on the proposed prospective payment system (PPS) for Medicare submitted by the Secretary of Health and Human Services.

BACKGROUND

IHC Hospitals, Inc. is concerned with the rising costs of health care. We strongly support the current reform movement in the Medicare system as a step toward curbing these rising health care costs. We endorse wholeheartedly the Medicare Health Insurance Certificate Proposal of the

Associated Hospital Systems, which we understand has been submitted to this Subcommittee, as the most promising and effective reform. We would recommend continuation and intensification of efforts to develop this proposal as the future design of the Medicare payment system. However, we realize that such development may take some time and that both Congress and the Administration are seriously considering a DRG-based prospective payment system. Accordingly, our remarks will focus on suggestions which we believe would refine and improve the HHS Secretary's prospective payment proposal as an interim measure.

The basic intent of the PPS as proposed by the Secretary is to revise the incentives of the Medicare payment system. IHC Hospitals endorses this objective. Over the past several years, cost reimbursement has encouraged hospitals to spend money. On the other hand, a prospective payment system motivates hospitals to increase efficiency and minimize costs in order to avoid losses and to retain the difference between the prospective payment and the actual cost. This incentive offers a reward to efficiently operated hospitals.

We also support a prospective payment system based on diagnosis-related groups (DRGs). This system attempts to identify and set payment based on the acuity of individual cases, rather than an overall average for all cases as in TEFRA.

IHC Hospitals agrees with the Secretary that capital costs should be excluded initially from the prospective payments for DRGs. We stand ready to work with Congress and the Secretary to analyze the issues involved in including payments for capital costs in a prospective rate at some future date. We also agree that both direct and indirect costs associated with medical education programs in hospitals should be paid separately from the prospective payments for each DRG. We concur with the Associated Hospitals Systems' recommendation on this issue.

While we broadly support the overall concept of prospective payments as an interim measure, we would like to bring your attention to a number of specific changes which we believe would enhance the current HHS proposal. These concerns are discussed below.

Administrative Discretion

We believe the final legislation implementing a prospective payment system should contain sufficient specificity so as to remove the possibility of administrative discretion in the initial establishment and subsequent adjustment of the DRG prices. The legislative specifications should apply to all aspects of the price setting methodology as well as to capital costs and teaching costs, both direct and indirect.

Over the past two decades, hospitals have experienced certain problems relating to the interpretation of legislative provisions which provide for administrative rule-making and discretion. For example, hospitals and administrators have committed significant resources in attempts to resolve questions of allowable costs and other related issues. By removing administrative discretion from this area of the program, we can avoid such costly and unnecessary legal actions.

Scope of the PPS

We believe the prospective payment proposal should be limited in scope and applicability to the Medicare program. States should be permitted to continue to contract in a variety of ways for Medicaid beneficiaries. Private insurers, self-insured employers and individuals without insurance should not be covered under this prospective proposal. We believe that the free market should determine the prices that hospitals will charge non-Medicare beneficiaries.

Benefits

We also believe that Congress should take this opportunity to specifically identify certain non-covered procedures. Technology continues to advance at a very rapid rate and many of the new medical innovations will lead to very costly procedures. We point to the implantations of artificial organs and organ transplants as examples. If Congress is to control federal expenditures for health care, we believe Congress has a responsibility to tell the American public the services for which payments will not be made.

Administration

At the present time, hospitals receive payments from fiscal intermediaries under the periodic interim payment (PIP) method. We believe that the PIP system should be continued under the prospective payment system. A simple settlement calculation at the end of the year could be performed to determine whether a hospital has been underpaid or overpaid. A proper settlement could then be made.

Hill Burton Requirement for Participation in Medicare

The administration's proposal states that hospitals can either accept the DRG rates as payment in full or terminate participation in the Medicare program. However, hospitals with Hill Burton funds are required to offer services to Medicare patients as part of their on-going community service obligation. We recommend that this Hill Burton requirement be repealed to allow each hospital the actual opportunity to decide whether to participate in the prospective payment Medicare system.

Medicare Bad Debts

The administration's proposal is silent on bad debts resulting from Medicare patients' failure to pay the existing statutory deductibles and coinsurance amounts. We believe that bad debts arising from such failure or inability should be reimbursed as Medicare bad debts.

Physician Incentives

The prospective payment proposal contains a number of very strong incentives for hospitals to contain costs and eliminate unnecessary procedures. IHC Hospitals believes that the hospitals in our system are doing an excellent job in containing costs in minimizing excessive utilization of services as is demonstrated by our system-wide average length of stay of 5.2 days. While a prospective payment system would encourage us to try to be even more efficient, it does nothing to change the incentives associated with physician reimbursement.

The current method of paying a physician for doing more is inconsistent with the prospective payment incentive of encouraging hospitals to do less. Given the new economic incentives of a prospective payment system, hospital managers will undoubtedly find ways to place some limits on physicians' utilization of services. But, in our view, the real savings will not come about until the federal government changes the way it pays physicians for services.

Accordingly, we believe Congress should consider the practicality of paying physicians the same way it pays hospitals, i.e., a prospective price for a given case type. This would align hospital and physician incentives and would give the physicians the same opportunity to benefit by providing needed services efficiently.

We recognize that it may be impractical to change physician payment by October 1, 1983, but we encourage Congress to require the Secretary to report on such a system within the next year. In the long run, such a payment system for physicians will do far more to control program costs than HHS's present proposal of simply delaying increases in physician fees.

MEDPAR File: Statistical Variations

The MEDPAR file, a 20 percent sample of Medicare claims, forms the basis for determining the number of cases in, and the relative cost weighting index of, diagnosis related groups. It is our understanding that this file contains a significant number of errors -- perhaps as high as a 40 percent error rate. The Secretary asserts that these errors are random and will be corrected by "a law of large numbers". If it is assumed that a "law of large numbers" is valid, such a law would be helpful only if: (1) the errors are actually random, and (2) it applies to hospitals with large volumes of discharges.

We are not convinced that the MEDPAR errors are random. A strong and convincing case can be made to support the allegation that the MEDPAR file contains systematic errors which tend to understate the relative intensity of the entire case mix file. This allegation is based on the fact that the MEDPAR file's clinical data was obtained from claim forms which were often prepared within two to five days of discharge, many days before the preparation of final discharge abstracts containing accurate clinical data.

In order to correct the potential technical errors contained in the MEDPAR files, we offer three recommendations. First, we suggest that an independent statistician, possibly from the GAO, review the Secretary's proposal to verify the statistical validity of the methodology.

Second, we suggest that an independent outside group be established to perform an evaluation of the accuracy of the DRG assignments appearing in the MEDPAR file. We believe this could be accomplished by selecting a random sample and examining either the specific medical records involved for those patients or their final diagnosis as entered into a national data base similar to that maintained by CPHA (Commission of Professional & Hospital Activities).

Finally, we recommend that the evaluative review of the MEDPAR file lead to specific recommendations, including specific time frames within which the data is to be corrected.

DRG Weight Assignments: Not Related to Cost

The proposed methodology for the DRG weight assignment does not yield an accurate reflection of the hospitals' costs of providing services for DRGs. The Secretary's method uses a simple average of daily routine costs, which includes such varied costs as those incurred in obstetrics, pediatrics, medical, surgical, short term psychiatric, rehabilitation, etc. Even though the costs for providing these services vary significantly, the Secretary's proposal recommends the use of an average of all these costs times the number of routine patient days to determine the average routine cost in each DRG. The same problem occurs in the special care area where costs of all special care unit costs are added together and then averaged.

Rather than being evaluated individually, each ancillary department is placed into one of seven groups: operating room, laboratory, radiology, drugs, medical supplies, anesthesia, and other. The total departmental grouping ratio of cost to charges from the Medicare cost report is applied to the specific patient charges accumulated for each DRG. This methodology for determining costs in the ancillary areas would be correct only if hospitals had exactly the same markup for all services provided in each of those seven groupings.

The end result is something that the Secretary refers to as "cost" weights, when in reality the weights bear absolutely no relationship to the actual cost of services for each DRG.

To more accurately reflect costs, we recommend that: (1) an actual determination of costs be made; (2) another methodology be developed which approximates more accurately the actual costs incurred in each DRG; or (3) the notion of developing the weights based upon "cost" be abandoned and replaced with a national average hospital charge per DRG.

Determination and Payment of the DRG Price

The method employed to set the initial prices for DRGs is of utmost importance to the success of a prospective payment plan. The prices must be low enough to encourage provider efficiency and high enough to assure the long range viability of efficient hospitals and the ability for Medicare patients to receive services.

In the past the full costs of treating Medicare patients have not been paid by the government. Consequently, hospitals have been forced to shift Medicare costs to non-Medicare patients in the form of higher charges. This type of cost-shifting, which is basically a hidden tax on the American people, should be changed in the prospective payment system. We believe that the government has an ideal opportunity to reduce or eliminate cost-shifting without regulating private insurance (see section on Scope of PPS, supra).

To eliminate cost-shifting, we believe that the full cost of providing services plus a reasonable return must be included in determining the prospective payment rate for each DRG.

To compute a total average payment amount per case we would recommend the following:

1. Determine the national average charge per case from the MEDPAR files.
2. Adjust the average charge downward to eliminate depreciation, interest and medical education. This could be accomplished based on a percentage relationship of those costs to total costs as given on the Medicare cost reports.
3. Determine the salary and non-salary component of the remaining amount (again by percentage relationships) from the Medicare Cost Reports.
4. Adjust the salary component of the average charge by the Urban/Rural Wage Index.
5. Add back the non-salary component of the average charge to determine the total locally adjusted average payment per case.

To determine the payment for each DRG we recommend using a method similar to the Secretary's with one exception: rather than using the average "cost weight" per DRG, use the average charge weight per DRG. This information could be obtained from the MEDPAR file. A specific formula to include anticipated inflation and technology changes should be set legislatively to update subsequent year payment rates (see section on Administrative Discretion, supra).

Realizing that the government is attempting to control their portion of Medicare payments, we agree that the prospective payment rate should be considered payment in full but recommend that the payment for each case be shared by the government and the beneficiary. The amount of payment for each could be set by determining the amount per average case the government is willing to pay and assigning the remainder to the patient.

The amount of patient liability for all DRGs could be expressed as a constant percentage or dollar amount. In this manner the beneficiary would know beforehand how much (or what percentage of the total) he would be liable to pay for each hospital stay. Under this scenario, the existing inpatient beneficiary deductibles and copayments would be replaced by the proposed DRG patient copayment described above.

We realize that not all Medicare patients will be able to pay the copayment and that some Medicare patients may be reluctant to seek needed treatment. To avoid these problems, a graduated percentage approach based on the amount of income of each Medicare recipient could be developed, lower income Medicare patients would be required to pay a smaller percentage of the DRG patient copayment than higher income Medicare patients. Any number of income brackets could be designated under this proposal.

Regardless of the method employed to determine prospective prices, we recommend that a comprehensive study of the methodology and its effects on hospitals and patients be legislatively mandated after the first two years of the program. This would allow potential inequities in the DRG prices to be corrected and DRG prices adjusted for future payment. In addition, further developments in vouchers could be reviewed, and both systems compared for future payment mechanisms.

SUMMARY

IHC Hospitals, Inc. supports the concept of prospective payments as a means of realigning provider incentives with Congressional and Administrative intent -- to provide quality hospital services efficiently. In order to accomplish this purpose, the prospective payment plan proposed by the Secretary of Health and Human Services needs to be revised to ensure that Medicare payments to hospitals for services rendered will be just and equitable, that is, that they will be set at a figure which will encourage provider efficiency while assuring both long range viability of efficient hospitals and accessibility of services for Medicare patients. Adoption of the recommendations explained above will help in accomplishing these desirable ends.

STATEMENT OF THE
NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

Dear Mr. Chairman:

The National Association of Private Psychiatric Hospitals (NAPPH) appreciates this opportunity to submit its comments with regard to the Administration's Medicare prospective payment proposal. This Association has been actively involved in working with the Department of Health and Human Services to assure that the special needs of the psychiatric hospitals are recognized in any plan which is proposed.

NAPPH represents the nation's freestanding (nongovernmental) psychiatric hospitals, comprising approximately 23,000 beds. These hospitals, with a variety of types of ownership, provide for the medical care and treatment of persons suffering from psychiatric disorders and impairments. The membership offers a wide range of comprehensive programs that are vital to address the needs of children, adolescents, adults, the elderly, the alcoholic, and the substance abuser. All of our member hospitals are accredited by the Joint Commission on Accreditation of Hospitals.

NAPPH has previously stated its support for imaginative and innovative proposals that would correct the present deficiencies in hospital reimbursement and provide for equitable payment methodologies. In considering the multiple elements common to the operations of psychiatric hospitals, any payment methodology must take into account items such as the development of patient treatment programs, adjunctive therapies, quality assessment programs, and costs associated with providing various treatment modalities.

Congress has long recognized the importance of these activities with respect to the unique programs of psychiatric hospitals and the differences between psychiatric hospitals and acute care general hospitals. Examples of such recognition exist within the Conditions of Participation for psychiatric hospitals in the Medicare and Medicaid programs where the government has explicitly stated that therapeutic services, specific medical record-keeping and staffing levels be required of psychiatric hospitals. The Conditions of Participation do not require nor mention these services for psychiatric units in general hospitals.

Furthermore, Section 101 of the recently passed Tax Equity and Fiscal Responsibility Act of 1982 specifically requires the Secretary of the Department of Health and Human Services to consider the special needs of psychiatric hospitals in developing exemptions from and exceptions to the new cost limits which have been based on a case mix adjustment. We believe this committee, and Congress, was correct in its judgment when it determined that a case mix index (CMI) was designed only for application in short-term acute care general hospitals.

As Congress begins its consideration of the Administration's prospective payment plan, NAPPH feels compelled to point out the inapplicability of any diagnostic related grouping (DRG) based payment system to the specialty psychiatric hospital. NAPPH supports the Department's concurrence with our recommendation to exclude psychiatric hospitals from its proposal on the basis that "DRGs were developed for short-term general hospitals [and] their application to [psychiatric, long term care, and pediatric] hospitals would be inaccurate and unfair." The Department further recognized that the difference in lengths of stay between psychiatric hospitals and psychiatric units of short-term hospitals would essentially result in the exclusion of psychiatric hospitals. Furthermore, NAPPH would like to point out that psychiatric hospitals were not included in the data base used by the Department. The psychiatric DRGs were based solely on general hospital data. While these factors begin to speak to the limitations of applying DRGs to the specialty psychiatric hospital, it is imperative that Congress understand that it is the unique nature of the psychiatric hospital and its services which precludes its inclusion in a system that classifies patients into groups that use length of stay as the primary measure of resource consumption.

The psychiatric diagnostic approach cannot be quantified to an extent that permits uniform classification by diagnostic related groupings. Of foremost importance in determining the treatment approach for a mentally ill patient is the degree of the severity of illness. The symptomatology manifested in each psychiatric diagnostic category varies with the unique characteristics of each individual patient to the extent that different plans of treatment (and, consequently, lengths of stay) are necessary. The DSM-III accounts for this variation in treatment by explicitly recognizing the multiplicity of factors with a multi-axial system of classification which accounts for primary diagnosis and secondary personality strengths and liabilities, accompanying physical disorders, relevant stress factors, and the level of functioning the individual achieved before the onset of illness. The DSM-III's ten major diagnostic categories, including 319 diagnoses, relate individual treatment needs to desired outcome without reference to time limitations.

Length of stay is a particularly inappropriate basis for determining diagnostic groupings for psychiatric patients in specialty hospitals. Treatment of the physically ill generally can be related to a specific time frame. Treatment planning for the psychiatric patient in a specialty hospital depends significantly on the intensity of the patient's illness and a variety of other factors including: a patient's functional disability, environmental situation (such as socio-economic status), past history of illness, acceptance of treatment, and a supportive family and community network. DRGs do not take account of these unique circumstances. The payment system proposed does not account for all of the factors that dramatically affect the desired outcome and length of stay of treatment in a psychiatric hospital. The application of this system to psychiatric hospitals would violate two of the prerequisites that the original researchers at Yale University used to develop DRGs: (1) that the number of classes in the system be manageable, and (2) that the classes contain patients with similar expected measures of output utilization (such as length of stay). The application of DRGs to psychiatric hospitals is not conducive to either qualification.

The limitations in applying DRGs to the specialty psychiatric hospital have been recognized in the two states that currently implement a DRG-based reimbursement system - New Jersey and Maryland. Psychiatric hospitals in New Jersey are scheduled to enter the DRG program in January 1983. However, New Jersey officials are currently reevaluating the applicability of DRGs to psychiatric hospitals and are reviewing the appropriate means to exempt the specialty psychiatric hospitals from the program.

Maryland, which utilizes a variation of the DRG system, does not include psychiatric hospitals in its DRG program. Hal Cohen, Ph.D., Director of the Health Services Cost Review Commission, has stated that DRGs were "essentially not developed with psychiatric diagnoses in mind... [and] to think that psychiatric patients can fit into four or five categories is absurd." The Health Services Cost Review Commission is requesting legislative changes to exempt psychiatric hospitals from its jurisdiction.

While a DRG system is not applicable to psychiatric hospitals, NAPPH does support the concept of prospective payment. However, it should be noted that with respect to Medicare, psychiatric hospitals represent an extremely small portion of hospital reimbursement, and therefore, are not a major cause of the increases in Medicare costs to the federal government. According to NIMH, in 1977, psychiatric hospitals represented a mere seven-tenths of one percent of the total amount reimbursed for all hospital care. This figure represented an increase of only one-tenth of one percent since 1969. In 1981, all psychiatric hospitals (both public and private) accounted for approximately $176 million out of the $40 billion Medicare program.

NAPPH believes that it would be in the best interest of the Medicare beneficiaries, psychiatric hospitals, and the federal government for Congress and the Department to work with the Association to determine if, how, and when psychiatric hospitals can be brought under the current DRG-based prospective payment proposal. NAPPH also believes that Congress should maintain the authority to determine the appropriate time such hospitals are included in the prospective payment plan.

We look forward to working with you and your committee to develop a prospective payment system applicable to psychiatric hospitals.

STATEMENT ON
MEDICARE PROSPECTIVELY DETERMINED REIMBURSEMENT TO HOSPITALS

Presented to the
Senate Finance Committee

The Massachusetts Hospital Association commends the Congress on establishing an appropriate direction for future Medicare hospital reimbursement. Prospectively determined reimbursement is the most prudent and equitable approach yet developed to the problem of escalating Medicare expenditures for hospital services. Continued reliance by Medicare on cost based reimbursement measures such as penalties and non-recognition of hospital cost items threatens the financial viability of a substantial number of hospitals and consequently continued access to quality health care by Medicare beneficiaries.

The very constructive proposal submitted by the Secretary of Health and Human Services has a number of shortcomings, we believe.

1. The proposed system is clearly an "experimental" approach since it has not been tested as proposed. The system would set a price per discharge according to Diagnosis Related Groups(DRG) using a different methodology than that used in New Jersey. The New Jersey system covers all payors with prices based on complete cost data on all patients and with more liberal provisions for atypical cases.
2. The proposed system, even though itself "experimental", does not provide for state or regional experiments of

alternative systems. This "all the eggs in one basket" approach is much too risky both for the national government and hospitals. Any legislation authorizing prospectively determined Medicare reimbursement should include provisions for continuation of existing waiver demonstrations, as well as provisions for approval of new demonstrations of alternative prospective payment systems. Of course, the demonstrations must continue to meet current requirements that they do not result in Medicare expenditures over a three years period in excess of what would otherwise have been spent.

3. The proposed system relies from day one on the national average price per DRG discharge. This approach would mean substantial profits for some hospitals and substantial losses for others. Some areas of the country (Massachusetts for example) would be faced with such substantial hospital financial losses as to threaten continued financial viability of their entire hospital system. We don't believe that such drastic local impact is in the national interest. Instead we believe the base for the price per discharge should be related to an institution's own cost. Of particular concern is reimbursement of teaching hospitals which would be severely impacted unless their specific costs are considered in the price per discharge.

4. The proposed system is far too permissive in leaving to the Secretary's discretion updates to prospective rates. In order for the system to have credibility with hospitals it is necessary to build into the system a guaranteed and objective adjustment which regularly updates the prospective rate. We

believe that the prospective rates should be adjusted to reflect hospital market basket inflation plus an allowance for new technology and increases in intensity.

Any transition to prospectively determined reimbursement will have "real world" consequences on hospitals, their employees, and patients. It may be of interest to the Committee what these consequences have been in Massachusetts.

Since the implementation of our state's new hospital reimbursement system on October 1, 1982, the following issues have arisen regarding impact:

1) A number of hospitals were severely disadvantaged and remedial legislation has been proposed to correct specific problematic provisions in the original statute. It is extremely difficult to foresee in detail the impact of innovative systems, and all interested parties must remain flexible and committed to resolving problems which are discovered upon implementation.

2) Hospitals have reduced budgeted employee positions in order to maintain financial viability. Since personnel costs on average approximate 60% of total hospital costs it should come as a surprise to no one that this is a consequence of a system designed to restrain hospital costs. The reductions were largely made in new and unfilled positions and by attrition, but some reductions had to be made by lay-off.

3) Hospitals are reviewing their service mix with an eye on services which are not justified in terms of medical cost effectiveness or in terms of paying their way. One consequence of this is that services utilized by the poor are vulnerable to cutback. This

is because government programs, such as Medicaid, which cover the poor, reimburse the lowest percentage of service costs. In addition, with cutbacks in eligibility, more of the utilization must be written off as free care and bad debt. In Massachusetts, Medicaid now reimburses, on average, only 72% of costs recognized by other payors, yet state government (as in many other states) is proposing further cutbacks in provider reimbursement. If such trends continue along with trends eliminating cost shifting, real access problems may materialize for the poor.

SJH/sab
(March 1, 1983)

February 17, 1983

TESTIMONY TO THE SENATE FINANCE SUBCOMMITTEE ON HEALTH ON THE PROSPECTIVE PAYMENT SYSTEM PROPOSED BY HEALTH AND HUMAN SERVICES

My name is Alvin Goldberg, Executive Vice President of Mount Sinai Medical Center of Greater Miami. I am pleased to have this opportunity to testify to the Senate Finance Committee on Health on the Medicare prospective payment proposal submitted to Congress by Health and Human Services Secretary Richard S. Schweiker at the end of 1982. Mount Sinai Medical Center, a 699 bed non-profit voluntary teaching hospital, has the distinction of providing services to the largest community of elderly in the country, Miami Beach, where 52% are over 65. Over 72 percent of our patient days were provided to Medicare patients in 1982. Therefore, we are very concerned that any prospective payment system adequately and fairly compensate hospitals for services provided to the nation's elderly.

While it is difficult, to assess the exact effect of the prospective proposal on individual hospitals as the Health Care Financing Administration (HCFA) has not yet released all the details to determine the anticipated reimbursement by DRG, there are several aspects of the proposal that we question. First, in calculating the index HCFA used the MEDPAR data base, a 20 percent sample of a hospital's Medicare admissions in 1981. Since this data base was designed only as a historical sample and not as a reflection of a hospital's case mix the quality of conclusions HCFA draws from the MEDPAR data is questionable. In addition, this data base does not account for the changes in medical practice between 1981 and 1984 (the year implemented).

Second, has the mix of services, as represented by the 1981 sample and the case mix index derived from the sample changed since 1981? HCFA has not made any allowances for such changes. In fact, HCFA considers any increases in Medicare admissions as being promoted only by incentives to take advantage of increased Medicare reimbursement offered by the regulations and will be accordingly adjusted downward. This attitude reflected in the prospective payment proposal (see pages 108-109 of the proposal) is also prevalent in the new Section 223 regulation recently promulated as per the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA):

> ... Under the reimbursement system established by P.L. 97-248, a hospital may have an incentive to increase its number of Medicare patients. For example, a hospital that has costs less than the target amount will receive an increased payment per discharge above its actual costs. We are concerned that some hospitals may promote the increased admissions of Medicare patients to take advantage of this aspect of the reimbursement system. Such action would be contrary to the intent of the legislation, which was to reward efficient operation, not to stimulate increased hospital admissions (Federal Register), September 30, 1982, p. 43825).

There are no stipulations for the increase in elderly population in a given service area or that population's aging and subsequent requirement for more inpatient hospital services.

Third, HCFA's data used to classify patients by DRG does not adequately account for multiplicity of diagnoses in patients, those patients who have more than one diagnosis during a hospital stay, and only accounts for, to a limited degree, complications that arise during his/her stay. In addition, the DRGs only address the age of the patients on a greater than or less than 70 basis. This could be a severe problem. Assigning one diagnosis related group to a patient on discharge, which dictates the reimbursement an institution will receive, may not consider or be sensitive to the fact that different patients or varying ages with the same principle diagnosis may be considerably sicker and thus require more intensive utilization of resources. Low income elderly particularly fall in that category more often than others. There is currently a study being undertaken by the National Association of Public Hospitals to explore this fact in more detail.

HCFA believes that the DRGs account for the severity of illness or individual cases and the requirement for these cases for more intensive services. To quote from the Health and Human Services proposal:

> ...the degree of severity of illness is not uniformly associated with treatment cost per case... Moreover, in DRGs where severity of illness is strongly associated with treatment cost, most hospitals will have patients that exhibit a range of severity levels. Thus, it is unlikely on balance that differences in the average level of severity across all DRGs for Medicare patients will cause any significant financial advantage or disadvantage to most general hospitals ("Hospital Prospective Payment for Medicare," December 1982, p. 54).

While this prospective payment proposal is more acceptable to hospitals than TEFRA's Section 223 provisions currently in effect, it is difficult to assess at this time the impact of reimbursement on hospitals. Whether the plan will compensate adequately for the increased costs associated with teaching programs (a lump sum for indirect costs of medical education is proposed by Health and Human Services while direct costs will be reimbursed as per the existing system), charity and bad debt, remains to be seen.

It is apparent that there still is widespread criticism of the plan and that hospitals may have a difficult time. Adjustments for multiple diagnoses appears limited. A typical case, involving either longer or shorter lengths of stay (i.e. outside the statistically valid range of days for a hospital stay) in a particular DRG, otherwise known as outliers, should be justified for an additional payment. HCFA believes that the number of cases falling in this category will only be approximately 0.5% of all cases. In New Jersey this figure is approximately 30%. This is clearly a major concern of hospitals nation-wide and is inadequately addressed to date by the federal government. The consequences of inadequate reimbursement to hospitals in New Jersey for the outlier cases would be financially devasting.

The DRG prospective reimbursement proposal's reduction in health care costs to the Medicare Program are real. However, the shifting of Medicare costs, not reimbursed by the federal government to other payors means private patients often covered by commercial insuors will be carrying an increased burden of costs. This has already been documented in the State of Florida by the Florida Hospital Cost Containment Board. It is estimated that in 1982 $64.79 per patient day extra costs are shifted to each non Medicare patient in Dade County because the Medicare program does not sufficiently reimburse hositals for their services to these patients. This amount would rapidly increase over time as the government tightens the screws in a Medicare only DRG prospective reimbursement system. New Jersey covers all payors. This remains as one of the primary differences between the Health and Human Services proposal and New Jersey's DRG system.

In summary, if a DRG prospective reimbursement proposal adequately accounted for teaching costs, severity of illness of patients, charity care, and bad debt provisions and was implemented for all payors (Medicare, Medicaid and commerically insured patients) then the system could be most beneficial to: patients; who would receive quality care with costs equitably distributed among all payors; hospitals, who would receive adequate reimbursement for services rendered; the federal and state government; who would have simplier bureaucratic structures and a restrained rate of health care costs increases; and private insurors, who would no longer bear the brunt of cost shifting encouraged by the present Medicare program.

NARF

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
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James A. Cox, Jr., Executive Director

Mr. Chairman:

Good Morning. I am Dr. John Goldschmidt, Vice President and Medical Director of the National Rehabilitation Hospital, Washington, D.C.. I am appearing today on behalf of the National Association of Rehabilitation Facilities (NARF), the American Academy of Physical Medicine and Rehabilitation, the American Congress of Physical Medicine and Rehabilitation, the American Physical Therapy Association and the American Occupational Therapy Association.

NARF is the primary national membership organization of medical and vocational community rehabilitation facilities. Our membership includes some 40 freestanding rehabilitation hospitals and about 80 rehabilitation units of general acute-care hospitals. Most, if not all, of these facilities are Medicare providers. The American Academy, American Congress and American Occupational Therapy Association represent professionals in the field of rehabilitation -- the physicians and occupational therapists.

Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) amended the cost reimbursement limitations on Medicare providers and required the Department of Health and Human Services to develop proposals for legislation which would provide that hospitals, skilled nursing facilities, and, to the extent feasible, other providers will be reimbursed under Medicare on a prospective basis. In response, the Department sent its report titled, Report to Congress: Hospital Prospective Payment for Medicare to Congress on December 28, 1982. The purpose of these hearings is to obtain reactions from health care providers and others affected by such a proposal. Our statement is in reaction to that proposal only. We are continuing to analyze it and other alternatives for their effect on rehabilitation facilities.

The proposal is outlined in Chapter III, "The Medicare Prospective Payment System Proposal." In summary, the Prospective Payment System Plan (PPS) proposes to pay hospitals a stated rate for each type of Medicare discharge. The rates are to be based on a "national representative Medicare cost per discharge for each Medicare patient Diagnosis Related Group (DRG)."

We have examined the PPS proposal and are pleased to note that it will exclude long term care hospitals which include most rehabilitation hospitals (Page 50). The Health Care Financing Administration has recognized that application of a DRG based methodology to these hospitals is "inaccurate and unfair." We had pointed this fact out to HCFA when it was developing the regulations to implement the new cost reimbursement limitations and PPS. As stated in a September 2 letter to Carolyne Davis, Administrator of the Health Care Financing Administration, the

DRG methodology and data are taken from the experience of short term hospitals which have an average length of stay of 7 to 11 days. Rehabilitation hospitals and units generally experience lengths of stay of over 30 days, and, those concentrating on very serious diagnoses, such as spinal cord and brain injuries, have much longer lengths of stay.

In the past, rehabilitation facilities have experienced no unusual problems with 223 limits since their per diem costs have been in line with other hospitals. However, the shift from a per-diem limit to a per-incident limit would also be inequitable.

Also, there would be incentive for acute care hospitals to discharge patients earlier. For rehabilitation hospitals this would mean patients are likely to be transferred from acute care to rehabilitation facilities at an earlier state of treatment necessitating longer stay in the rehabilitation hospital.

The interim final regulations published on September 30 exempted long term care hospitals from the new limitations. Long term care hospitals are defined by HCFA as those having a length of stay generally in excess of 30 days. Generally, they have a provider number in which the third digit is a "2", "4" or "7". This exemption includes most freestanding rehabilitation hospitals because they have a length of stay generally in excess of 30 days.

While we support the exclusion from the PPS proposal of long term care hospitals, the proposal does, however, raise two concerns. They are:

1. Rehabilitation Hospital Exclusion

In proposing the specific exclusions, HHS has recognized most of the special classes of hospitals by the type of malady (psychiatric) or type of patient (children) served. Rehabilitation hospitals are grouped with other long term care providers without any commonality other than their lengths of stay. Rehabilitation hospitals should be recognized under the exclusion specifically as rehabilitation hospitals. Such hospitals provide a unique series of services in a unique manner to a specific kind of patient. Length of stay is but one characteristic by which to differentiate hospitals. We recommend that any final proposal provide that a hospital that is accredited by JCAH as a rehabilitation hospital and that meets the Medicare Hospital Manual guidelines for hospital inpatient rehabilitation care be excluded from the prospective payment proposal.

2. Exclusion of Rehabilitation Units

The considerations which justify exemption of free-standing long-term hospitals including rehabilitation hospitals are equally valid for rehabilitation units of general hospitals. As noted above, NARF represents approximately 80 rehabilitation units.

The lengths of stay and case-mixes of such units are substantially the same as those of free-standing rehabilitation hospitals. Almost all such units have lengths of stay in the range of 30 days. As in the case of free-standing hospitals, the cost of rehabilitation units are in line with general hospital costs when examined on a per diem basis; however, because of the longer lengths of stay this picture changes radically when costs are calculated on a per incident basis or on a per discharge basis as they are proposed to be under the prospective payment system. Accordingly, most, if not all, cases in such units will exceed the per DRG level of payment. Also, as in the case with free-standing facilities the DRG system does not reflect the long-term rehabilitation cases and therefore the case mix adjustment figures for the general hospitals in which such units are located will understate the financial effect of rehabilitation units.

We suggest the Committee exempt rehabilitation units. The unique characteristics and cost experience of rehabilitation units (and others with similar characteristics) are currently recognized under Medicare. The Provider Reimbursement Manual at Part I, Section 2336 allows for designation of units as subproviders and for the filing of separate cost reports for each such identified element of a hospital.

This concept, already established by Medicare to deal with cost centers with widely varying cost experience, offers an appropriate means for addressing the unique position of rehabilitation units. Rehabilitation units should be permitted the same exemption as that of free-standing long-term hospitals provided that the unit has or obtains a separate subprovider identification number and meets the existing guidelines for inpatient rehabilitation care at Section 211 of the Medicare Hospital Manual.

This approach is consistent with the methodology used to construct the rates proposed by the prospective system. It is our understanding that the costs of units of hospitals with subprovider identification numbers are not included in the calculation of per incident limits. This mechanism is one way by which to exempt such units and is a logical extension of the policy of excluding their costs in calculation of the new DRG payment levels.

I would be pleased to answer any questions.

National Committee for Quality Health Care

PROSPECTIVE PAYMENT REFORM: PRINCIPLES AND GUIDELINES FOR ANALYSIS

Introduction

Prospective payment reform has all the earmarks of an idea whose time has come. The disincentives to efficiency which are inherent in the prevailing system of retrospective cost reimbursement have plagued the nation's health care budget for years. In the spring of 1982, the American Hospital Association took a first step toward ending the dominance of retrospective cost reimbursement by proposing a system of prospective fixed-price payments to hospitals under Medicare. At about the same time, it became known that the Health Care Financing Administration (HCFA) had constituted a task force charged with developing the Administration's own prospective payment proposal. In August, the Congress added momentum to the prospective payment movement by requiring the Administration to propose a prospective payment plan to Congress by early 1983. In October 1982, HHS Secretary Richard Schweiker publicly announced the board outline of his Department's prospective payment proposal.

The National Committee for Quality Health Care has resolved to add its voice to the emerging debate on prospective payment reform. To this end, a special subcommittee of NCQHC members was formed during the summer of 1982 to address this question. Specifically, this subcommittee was charged to: (1) assess prospective payment as an alternative to the currently prevailing retrospective cost reimbursement system for hospitals; (2) review and critique the various proposals which are offered by groups and organizations; and (3) formulate a set of recommendations to help guide health policymakers on the question of prospective payment reform. This document responds to the subcommittee's charge in two ways. First, it contains a statement of general principles which should be observed in the design of any prospective payment system by the federal government. Second, it contains a set of more detailed guidelines for analyzing and evaluating specific payment proposals. While these principles and guidelines focus on prospective payment under Medicare, we intend that they be useful in evaluating more broadly based prospective payment proposals as well.

The NCQHC is a diverse group of corporations and organizations which share an interest in rational reform of the health care system in this country. Its members are for-profit and not-for-profit hospitals, HMOs and other health providers, along with corporations, firms, and organizations which supply goods and services to health providers. Its trustees are physicians, hospital administrators, health professionals, and corporate executives. Since its members and trustees represent virtually all sectors of the health care industry, the NCQHC is particularly well situated to address the question of reforming the method by which the bellwether hospital sector is paid for its services.

General Principles

The following general principles should be observed in the design of any prospective payment system for health care programs financed by the federal government.

1. While the federal government may encourage prospective payment throughout the health care industry, it should be a requirement of federal law only under Medicare.
2. The federal government should not promise more care than it is willing to adequately finance through the prospective payment system.
3. The prospective payment system should be actuarially and financially sound.
4. The prospective payment system should afford financial predictability both to the government and to providers.
5. The prospective payment should pay a fair price, i.e., that price which allows an effective and efficient provider to furnish quality services while meeting its full financial requirements. These requirements include a reasonable return on investment, regardless of whether the provider is for-profit or nonprofit.
6. The prospective payment system should be administratively simple, and the payment rates should be objectively determined.
7. The prospective payment system should be equitable and should recognize that geographical differences and special circumstances impose differing requirements on providers.
8. The prospective payment system should have an appeal process.
9. The prospective payment system should maximize beneficiary cost-consciousness by involving the patient in the financial outcome of his treatment; patients' financial exposure must be limited by catastrophic coverage.
10. The prospective payment system should be seen as a step in the transition to locally determined, market-oriented payment mechanisms.

Guidelines for Analysis

The guidelines for analysis of prospective payment proposals fall into several categories. Each category is identified by a crucial aspect of any prospective payment system. The categories are as follows:

1. Benefits/Eligibility/Coverage: What benefits, patients, and payors are to be covered?
2. Determination of Payment: How is the payment, or "price," determined?
3. Cost-Sharing: What element of patient cost-sharing should be involved?
4. Reporting: What information must be reported by hospitals to payment agencies, and in what form?
5. Utilization Limitation: How will utilization levels be limited?
6. Administration: How should the prospective payment system be administered? Especially, how should the Medicare portion of such a system be administered by HCFA?
7. Special Problems: What provisions, if any, should be made for types of hospitals and types of costs which raise special problems (e.g., teaching hospitals, specialty hospitals, financially distressed hospitals, free care, bad debt, etc.)?

The guidelines which follow provide a framework of analysis for answering these questions. The questions themselves must be addressed, and answered satisfactorily, if prospective payment is to provide the financial controls and reform which are so badly needed by providers and payors alike.

Benefits/ Eligibility/ Coverage

1. The prospective payment system should be applied to the full range of inpatient and outpatient services currently reimbursed under Medicare.
2. Beneficiary cost-sharing provisions should be included; the current Medicare spell of illness requirement should be eliminated, and a co-payment requirement should apply to each admission.

Determination of Payment

1. Base year data used in implementing a prospective payment system should minimize the extent to which efficient providers are penalized and inefficient providers are rewarded.
2. A provider's performance under prospective rates during one time period should not affect the rates which are applied to this provider for subsequent periods.
3. Currently available data should be used in order to permit a phased-in implementation within a relatively short period of time, and without resort to complex formulas.
4. The payment system in both current and future years should permit the predictability of government expenditures and hospital revenues.
5. The development of base-year information should recognize the special circumstances of individual providers, differences in economic requirements because of regional variations, and the special requirements associated with medical education, research, maintenance of capital, charity care, bad debt, and malpractice insurance.
6. There should be an exception/exemption/appeal process for new hospitals, small hospitals, and hospitals with extraordinary costs beyond their control, and for other appropriate circumstances.
7. Cumbersome reviews and analyses of individual provider costs and revenues should be held to a minimum.
8. Determination of payments should balance risks and rewards in order to encourage efficient and effective hospital management.
9. Prospective payment rates should be updated at least annually, with provisions for interim adjustments to accommodate extraordinary cost changes which are beyond the hospital's control.
10. Caution should be exercised in using formulistic economic indices to update rates. Independent authorities should be consulted.

Cost-Sharing

1. Patient cost-sharing is essential in order to assure that the prospective payment system is actuarially and financially sound.
2. The patient's cost-sharing obligation should be linked to the patient's ability to pay.
3. For all patients, regardless of income, there should be a stop-loss or maximum payment figure, beyond which their cost-sharing obligation ceases.
4. The cost-sharing obligation should include a coinsurance feature.
5. The patient should be required to indemnify the provider for costs not covered by the system, up to the patient's stop-loss or maximum amount.

Reporting

1. The reporting documents should be stripped of all information requirements other than those which are reasonably necessary to determine program payment to the provider.
2. The reporting document should be simple and easy to understand.
3. Information which is desired by HCFA for reasons other than immediate administration of the payment system, e.g., as a data base for policy reform, should be acquired through surveys which are independent of the cost report form.
4. The current Medicare cost report form should be abolished.

Limits on Utilization

1. It is essential that there be independent monitoring or control to assure appropriate levels of utilization and to maintain high quality of care.
2. Physician involvement is essential to utilization control. The methodology for paying physicians should contain a financial disincentive to unnecessary utilization, and should be consistent with the hospital payment methodology.
3. Both inpatient and outpatient services should be covered by the prospective payment system, to the maximum extent possible, in order to avoid unwarranted shifting of costs and services from the inpatient setting to the outpatient setting.
4. Patient cost-sharing is essential to assure the actuarial and financial soundness of the system and as a buffer against unnecessary utilization.

Administration

1. Administration of the system should be delegated by HCFA to private sector payment agencies to the maximum extent possible.

2. HCFA's role should be limited to setting broad policy and monitoring and auditing performance of the payment agencies.

3. Provider appeals should be heard by a tribunal which is independent of HCFA.

4. HCFA should establish program-wide policies, and should determine any quantitative factors which are necessary for program-wide administration of the payment system, in consultation with independent experts.

5. The private payment agencies should set hospital-specific payment rates consistent with broad policy and program-wide quantitative factors determined by HCFA.

6. The payment agencies should be chosen through flexible means, including competitive bidding, with due weight being given to experience and ability.

7. The payment agencies shall be compensated on the basis of prospectively determined amounts.

8. Quantitative norms for the performance of payment agencies should be developed, and these agencies should be held accountable for attaining these norms.

Special Problems

1. The medical education and research functions should be segregated from patient care, and paid for separately.

2. The prospective payment system should give institutional providers a reasonable opportunity to preserve necessary capital.

3. The prospective payment system should include an equitable mechanism for paying such shared costs as free care, bad debts, and malpractice insurance.

4. There must be special provisions for financially distressed hospitals which uniquely fill a community need.

5. Special provisions must be made, if warranted, for small hospitals, rural hospitals, and specialty hospitals.

6. There should be special incentives for continued development of innovative delivery systems, e.g., HMOs, which have proven to be cost-effective.

FEBRUARY 17, 1983

"PROSPECTIVE PAYMENT FOR MEDICARE"
TESTIMONY BY THE NATIONAL MULTIPLE SCLEROSIS SOCIETY
BEFORE THE HEALTH SUBCOMMITTEE OF THE SENATE FINANCE COMMITTEE

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, THE NATIONAL MULTIPLE SCLEROSIS SOCIETY IS PLEASED TO HAVE THE OPPORTUNITY TO PRESENT IT'S PERSPECTIVES ON THE PROPOSED MEDICARE PROSPECTIVE PAYMENT SYSTEM. THE PRIMARY QUESTION WHICH WE HAVE ATTEMPTED TO INVESTIGATE IS HOW IMPLEMENTATION OF THE PROSPECTIVE PAYMENT SYSTEM WOULD IMPACT ON THE QUALITY OF HEALTH CARE SERVICES TO MEDICARE BENEFICIARIES WITH MULTIPLE SCLEROSIS. OUR TENTATIVE CONCLUSIONS ALSO HAVE IMPLICATIONS FOR MANY OTHER INDIVIDUALS WHO SUFFER FROM LESS COMMON DISEASES OR DISORDERS FOR WHICH THERE IS, AS YET, MARKEDLY LIMITED SPECIFIC THERAPY.

DRG PROSPECTIVE PAYMENT IMPACT ON QUALITY OF CARE

WE HAVE CONFERRED WITH A REPRESENTATIVE SAMPLE OF NEUROLOGISTS WHO DIRECT PROGRAMS OF QUALITY CARE FOR INDIVIDUALS WITH MULTIPLE SCLEROSIS ON AN IN-PATIENT AND OUT-PATIENT BASIS. SOME SIGNIFICANT DATA ON COSTS RELATED TO IN-HOSPITAL PROGRAMS FOR MULTIPLE SCLEROSIS HAS BEEN EXAMINED.

OUR PRIMARY CONCERN WITH THE PROPOSED SYSTEM OF ESTABLISHING A DIAGNOSTIC RELATED GROUP (DRG) ENCOMPASSING MULTIPLE SCLEROSIS AND ASSIGNING A SPECIFIC COST FOR PROSPECTIVE PAYMENT IS THAT IT IS LIKELY TO INCORPORATE SUBSTANTIAL DISINCENTIVES FOR THOSE HOSPITALS WHICH ARE PRESENTLY MOST CAPABLE OF PROVIDING APPROPRIATE

(over)

CARE FOR INDIVIDUALS WITH MULTIPLE SCLEROSIS AND IN ADDITION, TOTALLY DISCOURAGE FUTURE IMPROVEMENT IN THE MUCH NEEDED SERVICE MIX IN OTHER HOSPITALS. THE SYSTEM OF DETERMINING THE PROSPECTIVE PAYMENT FOR A DIAGNOSTIC RELATED GROUPING IS BASED ON A SAMPLE OF THE HISTORICAL COST DATA COVERING ALL TYPES OF HOSPITALS. BUT, IN THE CASE OF MULTIPLE SCLEROSIS AND MANY OTHER RELATIVELY UNCOMMON DISORDERS, THE "AVERAGE" IN-HOSPITAL MS TREATMENT PROGRAM DOES NOT NECESSARILY REPRESENT AN APPROPRIATE QUALITY OF HEALTH CARE.

THE WIDE RANGE IN AGE OF AFFECTED PERSONS, 15 YEARS THROUGH OLD AGE (85% NORMAL LIFE EXPECTANCY), PLUS THE TREMENDOUS VARIATION IN CLINICAL SEVERITY OF THE DISEASE FROM ONE PERSON TO ANOTHER AND WITHIN THE SAME PERSON OVER THE YEARS, PROVIDES PROBLEMS OF PAYING ON THE BASIS OF ONE DRG RATE FOR ALL THERAPY. IT MUST BE EMPHASIZED THAT WHILE MS AFFLICTS PERSONS OVER A WIDE SPAN OF YEARS, THE ONSET AND SOCIOECONOMIC IMPACT TO PRODUCTIVITY IN EARLY AND MIDDLE ADULTHOOD DEMANDS THAT SUBSTANTIAL INVESTMENT IN TREATMENT BE MADE WIDELY AVAILABLE.

WITH RESPECT TO MS, PROGRAMS WHICH ARE GENERALLY CONSIDERED GOOD, COST SIGNIFICANTLY MORE THAN THE "AVERAGE" COST. THUS, A DRG PROSPECTIVE PAYMENT TO ONE HOSPITAL WHOSE KEY PERSONNEL ARE UNABLE TO PROVIDE COMPREHENSIVE HEALTH CARE FOR MS PATIENTS MAY BE SUFFICIENT PAYMENT FOR THOSE LIMITED ASPECTS OF CARE THE HOSPITAL IS ABLE TO PROVIDE. BUT THE SAME PROSPECTIVE PAYMENT MAY BE WHOLLY INADEQUATE FOR ANOTHER HOSPITAL WITH A SPECIALIZED PROGRAM OF CARE FOR PERSONS WITH MS. THE RESULT IS INCENTIVES TO THOSE PROVIDING LESS THAN ADEQUATE QUALITY CARE AND DISINCENTIVES TO THOSE PROVIDING AN OPTIMAL QUALITY OF CARE.

OUR VIEWS ON THE DIVERSE QUALITY OF CARE FOR PERSONS WITH MS BY HOSPITALS IS NOT INTENDED TO BE AN INDICTMENT OF HOSPITALS. WE ARE OBSERVING SIGNIFICANT IMPROVEMENT IN THE CAPABILITY OF HOSPITALS TO PROVIDE THE APPROPRIATE MIX OF MEDICAL, SURGICAL, REHABILITATIVE AND PSYCHOLOGICAL SERVICES. HOWEVER THIS CAPABILITY IS NOT YET IMPLEMENTED TO A DEGREE THAT WOULD BE REFLECTED IN THE RETROSPECTIVE ANALYSIS DEFINING DRG COSTS. SUCH COMPREHENSIVE SERVICES HAVE BEEN DEVELOPED IN NUMEROUS HOSPITALS AND FROM THOSE EXPERIENCES IT WILL BE POSSIBLE TO DERIVE TRUE DRG ESTIMATES.

ONE SUCH HOSPITAL IS THE FAIRVIEW-DEACONESS HOSPITAL IN MINNEAPOLIS WHERE AN MS MULTI-DISCIPLINARY TEAM IS HEADED BY DR. RANDALL T. SHAPIRO. EXTENSIVE DATA HAS BEEN COLLECTED WHICH HAS NOT YET BEEN ANALYZED WITH RESPECT TO COSTS, BUT IT IS VERY CLEAR THAT THE AVERAGE HOSPITALIZATION (ABOUT ONE WEEK) INVOLVING NEUROLOGICAL SERVICES, BOWEL AND BLADDER MANAGEMENT, DRUG THERAPY, OCCUPATIONAL AND PHYSICAL THERAPY, PSYCHO-SOCIAL SERVICES, AND ALL REQUISITE NURSING SERVICES CANNOT BE SUPPORTED AT AN AVERAGE COST OF $1,899.38 - WHICH IS THE FIGURE LISTED FOR "DRG NUMBER 13: MULTIPLE SCLEROSIS AND CEREBELLAR ATAXIA" IN THE HEALTH CARE FINANCE ADMINISTRATION PRINTOUT ENCLOSED AS APPENDIX I OF THE DHHS REPORT TO THE CONGRESS ON HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE - DECEMBER 1982 (THE BLUE BOOK).

THE HIGHLY RESPECTED MS PROGRAM OF COMPREHENSIVE HEALTH CARE AT ALBERT EINSTEIN COLLEGE OF MEDICINE (AECM) IN THE BRONX, DIRECTED BY DR. LABE SCHEINBERG, WOULD NOT BE POSSIBLE FOR MS MEDICARE PATIENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM. AECM IS

AN EXAMPLE OF A TERTIARY, UNIVERSITY RESEARCH AND TEACHING INSTITUTION IN WHICH COMPLEX MS PROBLEMS ARE TREATED IN-HOSPITAL AND IN ADDITION, STUDIES ON COST-SAVINGS BY OUT-PATIENT THERAPY AND DAY-HOSPITAL PROGRAMS ARE BEING CONDUCTED. IN A ONE YEAR PERIOD 1980-81, 173 PATIENTS WERE TREATED IN-HOSPITAL FOR 3,486 DAYS, RANGING FROM 2 TO 80 DAYS FOR AN AVERAGE OF 20 DAYS. ON THE BASIS OF AECM REIMBURSEMENT RATE OF APPROXIMATELY $500 PER DIEM, COSTS AVERAGED 20x500 = $10,000. WHILE AECM IS ORGANIZED TO PROVIDE A MIX OF COMPREHENSIVE SERVICES, THE HIGH COST OF SUCH CENTERS IS ALSO BASED ON COMPLEX DIFFERENTIAL DIAGNOSES, TREATMENT OF INTRACTABLE URINARY AND PULMINARY INFECTIONS, SURGICAL INTERVENTIONS SUCH AS TENOTOMIES, AND SPINAL CORD SECTIONS FOR INCURABLE SPASTIC MUSCLE CONTRACTURE OR PAIN AND RECURRENT DECUBITUS ULCERS. IT BEARS EMPHASIS THAT WITH THE ADVANCING TECHNICAL COMPETENCE OF HOSPITALS AND MEDICAL PROFESSIONALS, AN INCREASING NUMBER OF HOSPITALS WILL BECOME CAPABLE OF SUCH COMPLEX THERAPIES.

IN MANY COMMUNITY HOSPITALS MS PATIENTS ARE ADMITTED PRIMARILY FOR THE PURPOSE OF ADMINISTERING AND MONITORING THE CLINICAL RESPONSE TO INTRAVENOUS ACTH (ADRENOCORTICOTROPHIC HORMONE). PROVIDED SUFFICIENT REIMBURSEMENT OR PROSPECTIVE PAYMENTS WERE MADE FOR THIS ON AN OUT-PATIENT BASIS, SOME HOSPITALIZATIONS COULD BE AVOIDED. THIS TYPE OF RELATIVELY INEXPENSIVE IN-PATIENT CARE IS QUITE DIFFERENT FROM THE MORE EXPENSIVE TREATMENT OF COMPLICATIONS AND SECONDARY SYMPTOMS SUCH AS BLADDER INFECTIONS, ETC., ALLUDED TO ABOVE. IT IS ALSO QUITE DISTINCT FROM THE PROGRAMS OF IN-HOSPITAL AND OUT-PATIENT COORDINATED, MULTISPECIALTY COMPREHENSIVE CARE WHICH OUR STUDIES INDICATE ARE BOTH COST EFFECTIVE IN COMPARISON TO

OTHER MODELS OF UNCOORDINATED AND FRAGMENTED INTERVENTIONS WHICH DO NOT PROVIDE HOLISTIC MANAGEMENT OF THE PATIENT AND FAMILY.

DESPITE THE EFFORTS TO DETERMINE HOW COSTS COULD BE DECREASED BY PROVIDING MANY DIAGNOSTIC STUDIES AND TREATMENTS ON AN OUT-PATIENT BASIS, PATIENTS THAT TRAVEL LONG DISTANCES FROM SPARCELY POPULATED AREAS, AS IS THE CASE WITH DR. SHAPIRO'S SERVICE AT FAIRVIEW-DEACONESS HOSPITAL, MAY REQUIRE HOSPITALIZATION IN ORDER TO RECEIVE THE BASIC SERVICES. ALTERNATIVE LOW COST HOSPITAL-ADJUNCT MOTELS WOULD HELP KEEP DRG RATES LOWER. IN CONTRAST THE URBAN METROPOLITAN SERVICE AT ALBERT EINSTEIN CENTER IN THE BRONX IS ABLE TO HANDLE A LARGER PERCENTAGE OF RELATIVELY HIGH COST PATIENTS ON AN OUT-PATIENT BASIS THUS PRESERVING THE IN-HOSPITAL SERVICES FOR MUCH MORE COMPLEX HIGH COST PROBLEMS.

THE POINT IS THAT WITH THE COMBINATION OF FACTORS REGARDING THE DISEASE ITSELF, THE VARIABLE CAPABILITIES OF HEALTH CARE FACILITIES, AND THE CURRENT LIMITS OF MEDICAL KNOWLEDGE ABOUT OPTIMAL AND PREDICTABLE TREATMENT FOR MANY SYMPTOMS OF THE DISEASE, THE PROSPECTIVE PAYMENT SYSTEM CURRENTLY RECOMMENDED WILL FAIL TO SUPPORT ADEQUATELY THE HOSPITALS WHICH ALREADY ARE PROVIDING HIGH QUALITY HEALTH CARE FOR PERSONS WITH MULTIPLE SCLEROSIS AND TOTALLY DISCOURAGE IMPROVEMENT IN CAPABILITY OF THOSE HOSPITALS MOVING TO FILL THIS NEED.

IN CONSIDERING WAYS TO ADDRESS THIS PROBLEM, WE HAVE THOUGHT OF SEVERAL POSSIBLE AVENUES OF APPROACH. ONE IMMEDIATE WAY TO COPE WITH THE PROBLEM IS TO INCLUDE DRG'S OF RELATIVELY RARE INSTANCE WHICH REQUIRE VERY SPECIALIZED SKILL IN THE SAME

CATAGORY AS THE OTHER TYPES OF CARE WHICH THE SECRETARY PROPOSES WOULD STILL BE REIMBURSED ON THE BASIS OF COSTS BECAUSE ADEQUATE STUDY HAS NOT BEEN DONE (E.G. PSYCHIATRIC, PEDIATRIC, ETC.). ANOTHER AVENUE MIGHT BE TO PROVIDE FOR PASS THROUGH REIMBURSEMENT FOR QUALITY CARE PROGRAMS IN THE SAME GENERAL WAY THE "OUTLIER" CASES WOULD BE COVERED. YET, ANOTHER APPROACH MIGHT BE SOME STRUCTURE BY WHICH EXPERTS IN THE TREATMENT OF MS ARE ASKED TO PREPARE A RANGE OF APPROPRIATE THERAPEUTIC TREATMENT MODELS WHICH WOULD BE USED TO ADJUST A PROSPECTIVE PAYMENT SCHEDULE FROM THE DATA BASED ON HISTORICAL "AVERAGE" TO A REASONABLE APPROPRIATE QUALITY OF COMPREHENSIVE CARE. WE ARE PREPARED TO ARRANGE ACCESS FOR THE SUBCOMMITTEE AND THE ADMINISTRATION TO PERSONS WHO ARE "EXPERTS" IN MS HEALTH CARE, AS IT IS DESIRED.

PAYMENTS FOR OBSERVATIONS ON THE EFFECTIVENESS OF NEW THERAPIES

IN THE CONTINUING SEARCH FOR SPECIFIC THERAPIES TO HALT OR REVERSE THE SERIOUS OUTLOOK IN MS, NUMEROUS TRIALS OF NEW DRUGS AND PROCEDURES ARE BEING CONDUCTED OR PLANNED. BECAUSE SUCH OBSERVATIONS ARE MOST EFFECTIVELY CARRIED OUT IN CLINICAL TEACHING CENTERS, IT IS RECOMMENDED THAT DRG PROSPECTIVE PAYMENT ADJUSTMENTS INCLUDE SUCH A CATAGORICAL APPROACH. SPECIFICALLY, IT IS RECOMMENDED THAT WITH REGARD TO TREATMENTS WHICH HAVE ALREADY UNDERGONE INITIAL TESTING AND BEEN REPORTED IN RESPECTED MEDICAL JOURNALS, REIMBURSEMENT SHOULD PERMIT EXTENSION OF SUCH OBSERVATIONS ON THE BASIS OF APPROVAL BY THE NATIONAL INSTITUTES OF HEALTH IN CONSULTATION WITH THE NATIONAL MULTIPLE SCLEROSIS SOCIETY. SUCH WORK SHOULD BE LIMITED TO ACADEMIC MEDICAL CENTERS WHERE MONITORING OF THE CLINICAL OBSERVATIONS CAN BE GUARENTEED. EXAMPLES OF THESE THERAPIES ARE

INTERFERON, PLASMAPHERESIS, HYPERBARIC OXYGEN, IMMUNOSUPPRESSIVE DRUGS, ETC. IN THIS REGARD, WE ARE ASSUMING THAT THE CONSTRUCTION OF THE "LUMP SUM" INDIRECT COSTS PAYMENT TO TEACHING HOSPITALS WILL INCLUDE THE COSTS OF CLINICAL TESTS AND PROCEDURES THAT HISTORICALLY HAVE BEEN THE BASIS OF NEW DIRECTIONS FOR THERAPY.

GENERAL PERSPECTIVES

THE NATIONAL MULTIPLE SCLEROSIS SOCIETY IS STRONGLY SUPPORTIVE OF FEDERAL, STATE AND PRIVATE EFFORTS TO CONTAIN THE HEALTH CARE COST INCREASES. WE BELIEVE THAT PHYSICIANS AND OTHER HEALTH CARE PROVIDERS CONTROL MOST OF THE HEALTH CARE COST DECISIONS FOR PERSONS WITH MS. THEREFORE, PROPOSALS AIMED AT DEVELOPING A MORE EFFICIENT HEALTH CARE SYSTEM SUCH AS PROSPECTIVE REIMBURSEMENT HAVE OBJECTIVES WHICH WE SHARE.

MOREOVER, SINCE COPAYMENTS AND COST SHARING ARE ALREADY A SUBSTANTIAL REALITY AND SINCE SOME APPROPRIATE MEDICAL THERAPIES AND EQUIPMENT ARE NOT CURRENTLY REIMBURSED, PERSONS WITH MULTIPLE SCLEROSIS AND THEIR FAMILIES ARE OFTEN ALREADY STRETCHED TO THEIR FINANCIAL LIMIT. SYSTEMS THAT WILL TEND TO MAKE THE HEALTH CARE PROVIDER SYSTEM MORE EFFICIENT MAY THEREBY ALSO REDUCE THE POTENTIAL OF ENACTMENT OF FURTHER COST SHARING AND COPAYMENT PROPOSALS WHICH WOULD PLACE AN EVEN GREATER BURDEN ON OUR PEOPLE.

HEALTH CARE COST CONTAINMENT, THROUGH WHATEVER MECHANISM, AS IT IMPACTS UPON THOSE DISABLED BY MULTIPLE SCLEROSIS AND MANY OTHER DISEASES OR DISORDERS OUGHT NOT BE CONSIDERED BY THE CONGRESS AS A HEALTH COSTS ISSUE ISOLATED FROM OTHER BUDGETARY IMPACTS. EVEN IF QUALITY MEDICAL CARE COSTS MORE, IT OFTEN HOLDS THE PROMISE

OF NOT ONLY IMPROVING THE QUALITY OF LIFE FOR INDIVIDUALS TREATED BUT OF REDUCING THE OVERALL FEDERAL BUDGET BECAUSE THE OTHER FEDERAL EXPENDITURES SUCH AS INCOME MAINTENANCE (E.G. SSDI) AND LONG TERM CARE MAY BE REDUCED AS A RESULT OF EFFECTIVE HEALTH CARE.

WE BELIEVE WE HAVE HIGHLIGHTED A PROBLEM WITH THE PROPOSED "PROSPECTIVE PAYMENT FOR MEDICARE" WHICH NEEDS TO BE EXAMINED AND RESOLVED PRIOR TO A TIME WHEN A NEW SYSTEM OF PROSPECTIVE PAYMENT WOULD APPLY TO SPECIALIZED MS TREATMENT PROGRAMS AND MS COMPREHENSIVE CARE CENTERS. WE ARE READY TO WORK WITH REPRESENTATIVES OF THE SUBCOMMITTEE AND OTHERS IN AN EFFORT TO PROVIDE THE TYPE OF DETAILED INFORMATION WHICH IS NEEDED TO CONSTRUCT A REASONABLE SOLUTION.

WRITTEN STATEMENT SUBMITTED BY:

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STANLEY BREZENOFF
PRESIDENT

STATEMENT OF STANLEY BREZENOFF, PRESIDENT OF THE NEW YORK CITY HEALTH & HOSPITALS CORPORATION TO THE HOUSE WAYS & MEANS SUBCOMMITTEE ON HEALTH ON THE ADMINISTRATION'S PROPOSAL FOR HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE

We are pleased to have this opportunity to comment on the Administration's proposed system for prospective payment of hospitals under Medicare. As public providers, we view this as a particularly critical time in the evolution of our national system of health care financing. The implementation of a well-developed prospective system of payment under Medicare would be a significant step forward in the effort to restrain health care costs while maintaining access to health care services.

In my statement for the record, I will describe how the Administration's proposed payment system as currently drafted would affect the New York City Health and Hospitals Corporation, the largest municipal hospital system in the country. I will also outline several measures which we believe must be included to insure the viability of our hospitals and our ability to provide for our patients, should a national prospective payment system be enacted. They are measures which, to varying degrees, underly the New York State system of payment which began evolving toward its current form in 1969. As you know, the State is currently operating under a three-year waiver from the Health Care Financing Administration which permits it to operate a prospective system of reimbursement under Medicare. In addition, the state reimburses prospectively under Medicaid and Blue Cross, thus including all major payors in our system.

Let me begin by briefly outlining for the record the exact nature of the Corporation that I represent as President. As I noted above, we operate the largest municipal hospital system in the country. It is comprised of 12 acute and four long-term care facilities, 36 community clinics and neighborhood family care centers and the emergency medical services system for the City of New York. We operate on a budget of $1.6 billion. Nearly one third of a billion dollars ($329 million) is funded by the New York City tax levy, $283 million by Medicare, and $702 million by Medicaid which in addition requires a 25 percent contribution by the City.

"HEALTH CARE IS A RIGHT"

We provided over 3.2 million inpatient days of care in our facilities last year, and 4.1 million outpatient visits. HHC provides care to all patients regardless of their ability to pay; the overwhelming majority come from poor and low income areas of the city. The poor socio-econmic status of our patients has a profound impact on their health status, which in turn influences the services we are required to provide.

Effect of the Proposed Payment System

It is this latter issue-- the special needs of poor and low income patients for care-- which is of particular concern to us, as we evaluate the potential effect of the Administration's proposal on our Corporation.

Specifically, we are concerned with the method of classifying patients into diagnostic related groups (DRGs) as a basis for determining rates of reimbursement. Research undertaken at John Hopkins University and elsewhere on this issue indicates that DRGs do not, contrary to the intent of that approach, produce homogeneous groupings of patients with respect to severity of illness. As a result, under a DRG-based reimbursement system, inner city hospitals serving more seriously ill patients within individual DRGs would be inadequately reimbursed for the care they provide.

Recently, our Corporation commissioned two separate studies* to determine how the population we serve influences the amount and type of services we deliver. The first study was specifically conducted to determine the potential impact of a DRG system on our hospitals vis-a-vis private facilities. The second study evaluated the medical needs of patients who were found by our State Department of Social Services to have excessive lengths of stay.

We are submitting copies of our studies for your staff to review. In addition we are providing a summary of these documents and related correspondence to HCFA which we hope may be included with our statement as part of the record.

The findings of both studies are extremely persuasive in documenting:

- o First, that in general, a greater intensity of service is in fact required by a disproportionate number of our patients, in comparison with patients served by private facilities; and
- o Second, that the DRG system is seriously deficient in taking into acccount the factors which are measures of the higher levels of care provided. In particular, it was found that our patients have a greater severity of illness and longer lengths of stay, which in turn are factors associated with higher costs.

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*"The Impact of Case Mix Measures on HHC Hospitals," by Jeffrey Merrill and Michael Schwartz; and Bellevue Hospital Center-- 1982 Length of Stay Appeal.

Last year, this Committee sought to address this concern through the enactment of Sec. 101 of the Tax Equity and Fiscal Responsibility Act of 1982. Under this provision, hospitals serving high proportions of Medicare and low-income patients were allowed an adjustment to their Sec. 223 cost limits, subject to the discretion of the Secretary of the Department of Health and Human Services. Unfortunately, no regulations have been promulgated implementing this provision of the law. We would hope that through our testimony we can illustrate the need for similar consideration under any national system of prospective reimbursement that is developed. However, we would also hope that the Secretary of the Department of Health and Human Services be required to issue regulations, so that implementation can be assured.

Although New York State's three-year waiver from the Health Care Financing Administration (HCFA) permits us to implement our own statewide system of prospective reimbursement under Medicare, we believe the resolution of this issue will establish an important precedent which will have profound consequences for us and for all public and inner city hospitals far into the future.

Over the past few months, we have working with the Administration in order to develop guidelines that could be used to implement the adjustment permitted under Section 101. In addition, it was anticipated that our efforts would be used as a basis for adjustments in the newly proposed DRG methodology for prospective payment. However, in the Administration's prospective payment proposal, it is noted on page 75 that "HCFA is planning to examine the extent to which certain groups of hospitals treat more costly cases within DRGs. However, no widely applicable method currently exists to make valid severity distinctions. In addition, data sets which could reflect severity are not universally applicable. These could take five to ten years to develop to the point where they could support a national Medicare payment system. DRGs have the distinct advantage of being based on available data. Nevertheless severity is one dimension that may warrant further study."

We must admit some degree of frustration with this response. We are pleased that the Administration has at least acknowledged the possible need for further research. However, we do not believe we can wait, while the appropriate data sets are being developed. Our need for assistance will be far more immediate, if the Administration's proposal were to be implemented as described in the document released in December.

As I noted above, the findings of our two studies lead us to the inescapable conclusion that unless the DRG approach is modified to adequately reflect our more complex caseload, not only would we be under-reimbursed for the care we provide, but there would be an accelerated shifting of high-cost patients from private to public institutions.

Given current encomic conditions, we have no doubt that this would lead to further disparities between public and private institutions in their capacity to provide quality care. While New York State hospital cost increases have averaged 9.8 percent, HHC's have increased at 7 percent. This disparity has been due in large measure to the severe fiscal pressures on our city tax base. These continued pressures, combined with accelerated cost shifting would inevitably mean that those requiring the highest levels of care would be served by institutions most seriouly impacted by the system of reimbusement.

Let me now turn to the specific concerns that we have with the DRG method of classifying patients, in relation to our caseload. As developed by HCFA, DRG's group cases for purposes of reimbursement on the basis of the principle diagnosis; presence or absence of a secondary diagnosis; presence or absence of a surgical procedure; age and discharge status. It is proposed that hospitals would receive a flat amount per DRG, regardless of the costs they incur in actually treating particular patients, and regardless of the length of stay. A newly drafted provision of the legislation would modify this approach slightly, giving the Secretary of HHS discretion to provide an additional payment where the stay exceeds 30 days of the mean stay within a DRG.

This overall approach causes significant problems for us, since specific factors which are more prevalent in our hospitals and which are associated with the significantly higher costs are not taken into account. These factors include:

o Multiple diagnoses-- HCFA's proposed method of classification takes into account only two diagnoses. Yet fully 55 percent of our Medicare patients have three or more diagnoses. These patients require a more intensive level of care and were shown to be the cause of our longer lengths of stay. Under the DRG system, length of stay is the single most costly factor in treating a patient.

o Severity of diagnoses-- Each DRG contains multiple diagnoses. We have found that in comparison with private facilities we have a greater proportion of diagnoses within DRGs which are associated with a greater severity of illness. One obvious example of this phenomenon is evidenced by our analysis of DRG 5 (original DRG developed by Yale New Haven). In this grouping of patients (which represents the medical diagnosis septicemia with and without surgery) nearly half (47%) of the cases in our hospitals had a principle diagnosis of tuberculosis, which is associated with a longer more costly length of stay. In contrast, in voluntary hospitals, only one-fifth (19%) of the patients had tuberculosis.

Moreover, the proposed DRG system does not take into account the nature of the secondary diagnosis; it only records whether it is present. Yet in our hospitals, a secondary diagnosis can frequently be the cause of a much longer, costlier length of stay than indicated by the principle diagnosis alone.

We found numerous other examples indicating a more intensive level of care is required within DRGs in public hospitals. The intensity of care was in turn found to be closely associated with the following patient characteristics:

- o High Proportion of Emergency Admissions-- Seventy-five percent of all our Medicare patients are admitted on an emergency basis. This has many costly implications not taken into account by HCFA's DRG system:
    - -- Intensity of Illness-- Our emergency admissions are sicker than elective admissions. They account for approximately 70 percent of all HHC patients admitted with three or more diagnoses.
    - -- Length of Stay-- Emergency admissions stay longer than elective admissions. In HHC, hospitals that have "excess days" (days over a predetermined standard per diagnosis), emergency admissions invariably account for 90-100 percent of the excess. This is not only because they are sicker, but because they lack prior medical records and pre-admission testing which would otherwise reduce their hospital stay.
    - -- Increased Staffing Needs-- High proportions of emergency admissions, particularly those involving unscheduled surgery, require a hospital to maintain peak staffing patterns at all times, even though they may not be fully utilized.

- o Income Level-- National surveys have consistently found that hospital stays differ by as much as 40 percent for poor patients. The proportion of cases with uniquely long lengths of stay (using the New Jersey trim points) in our hospitals average roughly twice the rate of that in the region's voluntary hospitals. The proportion of " outliers" at Bellevue is over twice that found among 25 teaching hospitals by a Yale-New Haven study and is almost twice the proportion found in five major New York City teaching hospitals-- despite the fact that these cases had a 95% PSRO approval rate.

- o Significant need for alternative level of care-- Many of our patients require an alternate level of care following their acute care episodes. However, shortages of nursing home beds coupled with problems that often arise when attempting to place poor patients in alternate care facilities lead to extended stays in our hospitals. The situation is particularly acute for Medicare patients who accounted for 57% of our alternate level of care cases in 1980.

How should the current proposal be modified to address these differences in patient mix? We would suggest three specific approaches:

- o First, the development of an adjustment specifically tailored to meet the needs of hospitals serving a more complex caseload. As indicated earlier in the Report to Congress on Hospital Prospective Payment for Medicare: "HFCA is planning to examine the extent to which certain groups of hospitals treat more costly cases within DRGs." Our Corporation is working with the National Association of Public Hospitals and HCFA to address the issue. We hope to have additional data in time to meet the needs of this Committee. Specifically, we will propose that adjustments be computed, which give appropriate weight to those factors which public hospital "outliers" have in common. These include: emergency room admissions, multiple diagnoses, mix of diagnoses within a DRG, discharge status, and payor status. Such adjustments would permit the DRGs to reflect the case mix in public hospitals and ensure equitable treatment under a reimbursement plan which utilized DRGs.

- o Second, by including an allowance for bad debt and charity care, to spread the cost of serving indigent patients in relation to the cost of such care provided. Such an allowance was just included in the New York State rate, which represents a significant step forward, particularly in recognizing the needs of the private sector to compensate for legitimate revenue shortfalls.

In addition we would recommend the following provisions, to address a number of other concerns we have with the proposal:

- o A requirement that the existing system be reviewed after a specific period of time, to assure the implementation of needed changes in the future;

- o The inclusion of an appeals process. In light of the sweeping changes that are being proposed, it seems unrealistic to develop a system without this added flexibility.

- o The inclusion of explicit incentives for further state experimentation in rate-setting, or the removal of disincentives. The Administration's draft proposal merely permits such experiments to continue. Meanwhile, HCFA is now requiring that all future waivers require DRG-based systems, and under waiver, NYS is required to operate its Medicare prospective system at 1 1/2 percent below national trend. Certainly there will be less incentive for state experiments in the future, given such restrictions.

Finally, we strongly urge this Committee to take the time that is needed to assure that adequate consideration is given to the many important issues raised by the Administration's proposed sytem. While we support the effort to develop a national prospective payment system in an expeditious manner, we do not believe it is possible to consider this important proposal in the same time frame as the Social Security reform package.

Given the experience we have had in New York, we believe the elements we have outlined are essential to protect the future viability of our institutions. We literally cannot afford to do less.

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION
BELLEVUE HOSPITAL CENTER
First Avenue and 27th Street
New York, N. Y. 10016

23 February 1983

Carolyne K. Davis, Ph.D.
Administrator
U. S. Department of Health
and Human Services
Health Care Financing Administration
Hubert H. Humphrey Building
Washington, D.C.   20201

Dear Dr. Davis:

I am writing in response to the letter which I received recently from Ms. Patrice Hirsch Feinstein of your staff regarding studies which I sent to you that reveal serious problems in the impact of Diagnostic Related Groups (DRGs) on public hospitals. I have reviewed the conclusions reached by you carefully and would like to offer several further observations.

Your staff indicated that it is unclear whether the outlier experiences under the original DRG scheme will be repeated under the new DRGs or HCFA's Medicare DRGs. Unquestionably, the outlier experience will change as the definition of trim points used to determine outliers changes. However, this does not negate the fundamental finding in the Merrill/Shwartz study which demonstrated that public hospitals have a larger proportion of atypical cases when compared to the expected length-of-stay.

Your staff also suggested that it is unclear whether the Medicare cases had the same patterns of outliers as total cases data from all payors. The following supplemental data taken from data collected by Merrill/Shwartz but not included in the final report shows that the number of outliers for Medicare cases is a much greater percentage of cases than the percentage of total cases which are outliers.

COMPARISON OF OUTLIERS
MEDICARE VERSUS TOTAL CASES(1)

DRGs	% of Medicare Cases which are Outliers	ALOS	% of Total Cases which are Outliers
DRG 6 - Infectious Disease with Surgery			
HHC (2)	29%	68	18%
Non-HHC	15%	38	5%
DRG 11 - Cancer of the GI system with Surgery			
HHC	17%	43	14%
Non-HHC	3.4%	26	3%
DRG 142 - CVA			
HHC	31%	40	30%
Non-HHC	16%	27	17%
DRG 145 - Circulatory Dysfunction in Brain with Surgery			
HHC	40%	70.5	31%
Non-HHC	14%	39	10%

(1) This is a partial listing. We would be pleased to provide an additional data set at your request.

(2) HHC - New York City Health and Hospitals Corporation.

With respect to source of admission, we recognize that admitting practices through emergency rooms vary greatly among hospitals. However, we believe that source of admission can serve as an adjustment variable if appropriate criteria are developed and would be pleased to work with you in the formulation of such criteria. In addition, your staff suggested that because Medicare patient volumes are higher in public hospitals, such hospitals are better protected by the "law of large numbers" from random variation by case type than are hospitals with few Medicare admissions. Data indicates that the Medicare patient volumes in urban public hospitals is not higher than voluntary hospitals. For example, a report published recently by the National Center for Health Services Research (Patients in Public General Hospitals: Are they Poorer and Sicker) shows that the proportion of revenues from Medicare patients in public hospitals located in SMSAs is

22.3 percent in comparison to 28.8 percent for voluntary hospitals in the same regions. Moreover, the "law of large numbers" works against public hospitals because, as the Merrill/Shwartz study demonstrated, public hospitals tend to care for patients with more complex diagnoses within DRGs.

With respect to payor type the Merrill/Shwartz study, like the Bellevue Length-of-Stay Appeal, included Alternate Level of Care days in the length-of-stay computation. It is important to include these days because they affect length-of-stay insofar as they reflect the difficult placement problems confronting many Medicaid patients.

With regard to discharge status, the following supplemental data taken from data collected by Merrill/Shwartz but not included in the final report shows that a higher proportion of outliers were associated with cases transferred from HHC facilities than those transferred from non-HHC facilities. The longer lengths-of-stay experienced by these cases lead to higher costs for care.

COMPARISON OF TRANSFERRED CASES
HHC VERSUS NON-HHC

DRG	Number of cases Transferred	ALOS	Number of Outlier Total Cases Transferred
DRG 142 - CVA			
HHC	58	85	41
Non-HHC	58	46	21
DRG 311 - Sterility			
HHC	201	19.4	85
Non-HHC	0	0 (3)	0

(1) This is a partial listing. We would be pleased to provide additional data at your request.

(2) ALOS for transfer cases.

(3) ALOS for the non-transfer cases.

In terms of multiple diagnoses, your staff suggests that the HHC finding of more cases with multiple diagnoses does not conflict with the HCFA DRG approach. You indicate that the HCFA DRGs and case mix index take multiple diagnoses into account when classifying cases. The HCFA DRG system accounts only for the presence or absence of a second diagnosis and procedure. Many of our patients suffer from three or more diagnoses which, by definition, make them sicker and more difficult to treat. The Health and Hospitals Corporation recently analyzed SPARCS (Statewide Planning and Research Cooperative Systems) data and found that 27 percent of all cases in HHC facilities in 1980 had three or more diagnoses while fully 55.5 percent of all Medicare cases had three or more diagnoses. The HCFA DRGs, like all other DRG systems, are not sensitive enough to take into consideration severity-of-illness. Consequently, I believe this unfairly discriminates against public hospitals since they treat a substantial proportion of patients with more than two diagnoses.

Finally, with respect to your comments about mix of diagnoses, we remain seriously concerned about the impact of the distribution of cases within DRGs, (the so-called within DRG effect). The attached chart taken from the Merrill/Shwartz report shows that the impact of the within-DRG effect on length-of-stay is highly significant. I am aware that your cost data does not indicate any measurable difference in costs between inner-city public hospitals and comparable hospitals, but this is attributable to the depressed budgets which public hospitals have had to live with for many years and not resource requirements. To perpetuate this inequitable fiscal situation is unfair to public hospitals and the patients they serve.

·Thank you for the opportunity to provide you with this additional information. I look forward to continuing to work with you closely on these vital issues. If you need any further information, please do not hesitate to contact me.

Sincerely,
Madeline A. Bohman
Madeline A. Bohman
Executive Director
Bellevue Hospital Center

Vice-Chairman
National Association of
Public Hospitals

MAB/mmc
att.

APPENDIX

Component of the Difference in Length of Stay Between Municipal and Non-Municipal Hospitals for Different Sets of DRGs

Hospital Grouping	DIFF LOS*	CASE MIX EFFECT	WITHIN-DRG EFFECT
ALL DRGs			
All hospitals	-0.06	-1.19	1.13
Teaching hospitals	0.44	-1.04	1.48
Non-teaching hospitals	-1.16	-1.61	0.45
MAJOR SURGERY DRGs			
All hospitals	3.58	-0.98	4.56
Teaching hospitals	3.89	-1.15	5.04
Non-teaching hospitals	2.96	0.40	3.36
DRGs WITH SECONDARY DIAGNOSES			
All hospitals	-1.36	-2.38	1.02
Teaching hospitals	-1.24	-2.55	1.31
Non-teaching hospitals	-1.47	-1.94	.47

* Length of stay in municipal hospitals minus length of stay in non-municipals.

HEALTH AND HOSPITALS CORPORATION
BELLEVUE HOSPITAL CENTER
First Avenue and 27th Street
New York, N. Y. 10016

6 October 1982

Carolyne K. Davis, Ph.D., Administrator
U.S. Department of Health and Human Services
Health Care Financing Administration
Hubert H. Humphrey Building
Washington, D.C. 20201

Dear Dr. Davis:

On behalf of the National Association of Public Hospitals, may I thank you for the opportunity to meet with you recently to discuss the special requirements of public hospitals in relation to the utilization of a case mix system within a prospective reimbursement plan.

Enclosed for your review is followup information which discusses the weaknesses of Diagnosis Related Groups when applied to public hospitals. As Harriet Dronska, Vice-President of the New York City Health and Hospitals Corporation (HHC), described during the September 29 meeting, two studies conducted by HHC indicate that public hospitals have a greater proportion of outliers than voluntary hospitals. This is attributable to:

- Source of Admission - 81 percent of HHC admissions were emergency room admissions compared to 25 percent in voluntary hospitals. Within this group, 94 percent of HHC teaching hospital outliers were emergency admissions versus 58 percent in non-HHC teaching hospitals;
- Payor type - public hospitals serve greater numbers of Medicaid patients who often require a longer length of stay due to poor medical conditions associated with low socio-economic status;
- Discharge status - public hospitals serve greater numbers of patients requiring transfer to a non-acute facility because they are homeless or have no families who can provide necessary post-hospital care.
- Multiple diagnoses - public hospitals serve large numbers of patients with multiple diagnoses requiring longer lengths of stay, and
- Mix of diagnoses - each DRG contains a variety of different diagnoses some of which are more complex than others. Public hospitals have a greater concentration of more complex diagnoses

within discrete DRGs. For example, within DRG 5 (Septicemia with and without surgery), 47 percent of the cases in the HHC hospital had tuberculosis while only 19 percent had tuberculosis in the voluntary hospitals.

I hope this information is helpful. Please be assured that we are available to work closely with you and your staff to develop adjustments which are needed to compensate for these weaknesses. Again, thank you for your time. I look forward to working with you on this critical matter.

Sincerely,
Madeline A. Bohman
Madeline A. Bohman
Executive Director
Bellevue Hospital Center

Vice-Chair
National Association of
Public Hospitals

MAB/mmc

Encs: 1) Overview
2) Bellevue Hospital Center 1982 Medicaid Rate Length of Stay Appeal
3) "The Impact of Case Mix Measures on HHC Hospitals: An Analysis" Prepared by Jeffrey Merrill and Michael Shwartz for HHC.

CC: Larry Gage, President, NAPH
Harriet Dronska, Vice-President
New York City Health and Hospitals
Corporation

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

OFFICE OF EXECUTIVE DIRECTOR
BELLEVUE HOSPITAL
'83 JAN -5 AM 9 54

December 23, 1982

Ms. Madeline A. Bohman
Executive Director
Bellevue Hospital Center
First Avenue and 27th Street
New York, New York 10016

Dear Ms. Bohman:

Dr. Carolyne K. Davis has asked that I respond to your letter sending the additional information concerning public hospital's case mix. Thank you for providing these materials.

After reviewing the material, my staff has made several general observations:

- It is not clear that the outlier experiences under the older DRG scheme will be repeated to the same extent under the newer DRG system or HCFA's Medicare version of it.
- Likewise, it is not immediately clear whether the Medicare cases had the same patterns of "outliers" as the total cases data from all payers.
- The New York City Health and Hospitals Corporation (HHC) study does not indicate how "outliers" were defined for purposes of the research.

On the specific points cited in your letter:

1. Source of Admission

   We may not be able to generalize from the findings that HHC experienced more admissions through emergency rooms, because admitting practices vary so greatly among hospitals. We might quarrel with some of the HHC study assertions about which case types are "less predictable" DRGs (for example "infectious diseases" and "injuries"). In the main, we believe that because their Medicare patient volumes are higher, public hospitals are better protected by the "law of large numbers" from random variation by case type than are hospitals with few Medicare admissions.

2. Payor Type

We cannot readily assess your "payor type" conclusion that Medicaid patients more often require a longer length of stay. The HHC study did not indicate that "Alternate Level of Care Days" (an important point in the Bellevue Appeal) were included in the lengths of stay computations.

3. Discharge Status

While as HHC experience suggests, public hospitals may have more patients discharged to other institutions, we have no evidence that acute care costs before live discharge are affected by the discharge status.

4. Multiple Diagnoses

The HHC finding of more cases with multiple diagnosis does not conflict with our DRG approach. Our DRGs and case-mix index take multiple diagnoses into account when classifying cases.

5. Mix of Diagnoses

Although the HHC study suggests that public hospitals have more complex cases within DRGs, our assessments to date show that the expected impact of Medicare total cost limits upon "large urban (inner city) public hospitals" is not markedly different than the impact upon other types of hospitals. But we have not ruled out the possibility that in some DRGs, public hospitals may treat more severely ill patients.

The finding of a more concentrated caseload in HHC hospitals would not invalidate the Medicare DRG relative weights or rates. In fact, if economies of scale exist, public hospitals could benefit. We are still examining the reimbursement issues associated with "outliers" including their programmatic definition, but, in our research to date using statistical definitions we observed no unusual concentration of outlier cases in public hospitals.

In summary, we have uncovered no evidence thus far which conclusively suggests that the Medicare case-mix index fails to adequately reflect differences in the Medicare patients treated in public hospitals. However, we will continue to examine our data to determine if there is evidence that public hospital Medicare patients overall or for particular DRGs are different from other Medicare inpatients in ways which could lead to deficient Medicare payments to public hospitals.

Please continue to provide us with any additional information or studies you may have on these important matters. I truly appreciate your taking the time and effort to work with us.

Sincerely yours,

Patrice Hirsch Feinstein

Patrice Hirsch Feinstein
Associate Administrator for Policy

CASE MIX MEASURES AND PUBLIC HOSPITALS
ANALYSES BY THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

OVERVIEW

INTRODUCTION

The introduction of Diagnosis Related Groups in the health care system represents an important development in the management of hospitals. DRGs provide a useful management and planning tool for institutions and may be particularly effective as a cost containment mechanism. Weaknesses in the DRG system with respect to severity of illness and multiple diagnoses (beyond major or minor secondary diagnoses) prevent DRGs from providing an adequate reflection of the case mix in public hospitals. As the following discussion will indicate, any formula which utilizes the application of DRGs for hospital reimbursement purposes must be adjusted for public hospitals in order to account for the special characteristics of their case mix and provide equitable treatment under a payment plan.

Two studies recently conducted by the New York City Health and Hospitals Corporation (HHC) point out the weaknesses of the DRG classification system when applied to public hospitals. These are 1) The Bellevue Hospital Center 1982 Medicaid Length of Stay Appeal and 2) "The Impact of Case Mix Measures on HHC Hospitals: An Analysis" prepared by Jeffrey Merrill and Michael Shwartz. The first was prepared by Bellevue Hospital for New York State in response to a length of stay penalty imposed on the hospital's 1982 Medicaid rate for days of care provided in 1980 judged by the State (utilizing a case mix measurement system) to be in excess of allowable lengths of stay. The second was conducted under contract from HHC by the investigators utilizing 1979 data to determine the impact of case mix measures on HHC hospitals in comparison to other, similar voluntary hospitals.

In general, these studies found that:

- -- DRGs are inadequate to describe a significant proportion of cases in public hospitals;
- -- Such cases, which become "outliers", are disproportionately prevalent in public hospitals; and
- -- Similar characteristics involving payor type, source of admission, and multiple diagnoses are common to these outliers.

DISCUSSION

Both studies (Merrill-Shwartz and Bellevue) found that public hospitals have a higher proportion of outliers than comparison groups.

Outliers as a Percent of Discharges(1)

HHC Hospitals	HHC	Non-HHC
Bronx Municipal	5.8	3.9
Lincoln	5.3	3.0
No. Central Bronx	4.0	1.7
Coney Island	3.5	3.3
Cumberland(2)	3.0	3.1
Greenpoint(2)	3.2	3.2
Kings County	5.0	3.9
Bellevue	6.9	3.9
Harlem	7.1	3.8
Metropolitan	5.2	3.8
Elmhurst	4.6	3.8
Queens	3.7	2.4

(1) Merrill Shwartz, page 31, Table 17

(2) These hospitals are slated for closure in FY 1983.

The Bellevue study found:

- In 1980, outlier cases accounted for 7.7% of Bellevue discharges and 39.3% of discharge days.
- Bellevue's proportions are over twice those found in a study of 25 major teaching hospitals conducted by Yale-New Haven Hospital. In that study, outlier cases accounted for 3.4% of discharges and 17.7% of discharge days.

- Bellevue had almost twice as many outliers as five major teaching hospitals in New York City in 1978. On the average, 4.4% of total cases and 30.8% of discharge days were outliers in the other teaching hospitals.

- The following table shows that Bellevue had substantially higher proportions of outlier cases and outlier days and a longer outlier length of stay in 1980 than did four other major teaching hospitals in New York City.

Proportion of Outliers at Bellevue and Other Major NYC Teaching Hospitals in 1980

Hospital Name	Outlier Cases as a percent of Total	Outlier Cases as a percent of Total	Outlier Average Length of Stay
New York-Cornell	4.4%	NA	33.6%
St. Vincent's	5.2%	26.5%	54.5%
Mt. Sinai	5.3%	21.8%	46.5%
Long Island Jewish (LIJ Unit)	3.6%	14.8%	38.4%
Bellevue Hospital	7.7%	39.3%	65.2%

Substantiating that the length of stay associated with these outlier cases was, in fact, due to medical necessity and not inefficiency is critically important. Using PSRO approvals as a proxy for determining medical need, Bellevue found that its outlies cases represented a 95% PSRO approval rate. This high rate of validation by PSRO coupled with the proportion of outlier cases in public hospitals supports the conclusion that public hospitals serve sicker patients in greater numbers.

The Merrill-Shwartz study found that the case mix in public hospitals is concentrated in fewer and less complex DRGs than voluntary hospitals. (See Tables 5 and 6, pages 16 and 17, table 7, pages 19-20, Merrill-Shwartz study). This conclusion requires reconfirmation with more recent data, since coding practices in 1979 may have been seriously deficient in relation to the comparison groups. Under any circumstances, three observations are in order:

1) Merrill-Shwartz discovered that within discrete DRGs, municipal hospitals have a greater concentration of more complex cases. This is attributable to the fact that each DRG includes a variety of different diagnoses, some of which are more complex than others. For example, within DRG 5 (Septicemia with and without surgery), 47% of the cases in HHC hospitals had tuberculosis while only 19% of the cases in the voluntary hospitals had tuberculosis. Tuberculosis has a longer length of stay.* Another example can be seen in DRG 77 (Diabetes). 71% of the HHC cases had adult diabetes compared to 59% in the voluntary hospitals. Adult diabetes has a long length of stay, generally 70 days. Moreover, 1-1/2% of the diabetes cases in HHC hospitals were related to ophthalmological problems as contrasted to 24% in the non-HHC hospitals. These cases are associated with a short length of stay of 4.3 days. Thus, within DRGs, the case mix complexity varies significantly between public and voluntary hospitals and may account for much of the difference in the proportion of outliers between the two groups.

2) Merrill-Shwartz found that the voluntary hospitals experience a substantially greater number of surgical cases than the HHC facilities. (16.7% of all discharges in voluntary hospitals versus 8.3% in HHC facilities. See Table 8, page 21, Merrill-Shwartz study). Under the DRG system, this would suggest that voluntary hospitals have a more complex case mix because DRGs define the presence of surgery in a case as a more complex case. However, this is misleading. The difference in the prevalence of surgical procedures between the two groups is attributable to the fact that voluntary hospitals perform significantly more elective or non-emergent surgery -- procedures generally associated with short lengths-of-stay. Therefore, the presence or absence of surgery does not alone define severity of illness or case mix complexity and may have little to do with an institution's performance respecting length of stay.

3) The DRG classification system is not flexible enough to account for new technologies which may replace surgical procedures but still have associated costs which are greater than the assigned DRG without surgery. An example of this is a newly developed procedure called invasive radiography. This technique, which is invasive but not surgical, utilizes special needles and catheters to drain internal abscesses.

Characteristics which Outliers have in Common

The examination of the characteristics of outlier cases reveals significant commonalities:

1) Admission source - Bellevue and Merrill-Shwartz found that a

*See also the discussion of severity of illness of tuberculosis patients, page 23 of the Bellevue study.

significant proportion of outlier cases were emergency room admissions. As would be expected, ER admissions have a greater severity of illness. Bellevue found that the length of stay of ER admissions is nearly twice that of elective admissions. (14.7 days to 8.4 days). More importantly, Bellevue found that 90% of their excess days, or days for which the hospital was being penalized, were associated with ER admissions. (See page 28 of the Bellevue study.) Merrill-Shwartz examined DRGs to determine the influence of admission source and found that in 56% of the DRGs reviewed, emergency admissions had a significantly higher length of stay than elective admissions. In 24% of the discharges, the opposite occurred (see page 43, Merrill-Shwartz report).

2) Discharge Status - Merrill-Shwartz found that discharge status plays an important role in determining length of stay. One variable, transfer to a non-acute facility, accounts for significant difference in length of stay between public and voluntary hospitals. In general, a greater percentage of patients in HHC facilities are transferred to a non-acute facility than in the voluntary hospitals. This may be attributable to severity of illness and domicile status (this refers to whether or not the patient has a home or family members who can assist in necessary post-hospital care). Merrill-Shwartz found that transfer patients generally have a longer length-of-stay, and that there are greater numbers of such patients in public hospitals which contributes to larger numbers of outlier cases. (see page 39, Merrill-Shwartz).

3) Payor Type

Merrill-Shwartz analyzed the impact of payor type on differences in length of stay and found that Medicaid patients tend to have a longer length of stay than Blue Cross or other private payor patients. (see pages 34-38, Merrill-Shwartz study). This is the case because Medicaid patients are from lower socio-economic levels which are associated with poor health conditions.* The length-of-stay experience of Medicaid patients is significant because Medicaid patients comprise a larger proportion of the patient population in public hospitals.

4) Multiple Diagnoses

The DRG classification system accounts for primary and secondary diagnoses. This is inadequate to reflect the medical condition of many public hospital patients. The following chart represents an analysis of Bellevue's 1980 discharge data. (pg. 29, Bellevue study).

*See discussion of socio-economic status, pg. 29 of the Bellevue study.

Bellevue Hospital Center

Analysis of Diagnoses per Case[1]

1980

No. DX/Case	% of All Cases	% of Excess Days
1	33.0%	-9.0%
2	27.0%	-34.0%
3	17.0%	1.0%
4	11.0%	29.0%
5	13.0%	112.0%
	100.0 %	100.0%

[1] Page 29, Bellevue study.

The findings of this analysis are significant: First, the analysis reveals that 41% of all cases had 3-5 diagnoses. Second, in the aggregate, those cases with 3-5 diagnoses represented the cause of the excess days. This demonstrates that patients with multiple diagnoses have a greater severity of illness and can be expected to require a longer length of stay than that which is allowed by the assigned DRG.

5) Within DRG Mix of Diagnoses

As indicated previously, Merrill-Shwartz found that within discrete DRGs municipal hospitals have a greater concentration of more complex cases. In general, cases which become outliers are those which represent the most complex diagnoses within a DRG.

CONCLUSIONS AND RECOMMENDATIONS

Based on the preceding discussion, it can be concluded that the DRG classification system is inadequate to accurately reflect the patient mix in public hospitals. Because of identified deficiencies, public hospitals experience greater proportions of outliers than their voluntary counterparts. Accordingly, adjustments must be made to correct for the system's deficiencies if DRGs are to be used for calculating institutional reimbursement. In this regard, it is proposed that adjustments be computed which give appropriate weight to those factors which public hospital outliers have in common. These include: emergency room admissions, multiple diagnoses, mix of diagnoses within a DRG, discharge status, and payor status (representing a proxy for socio-economic factors). Such adjustments would permit the DRGs to better reflect the case mix in public hospitals and ensure equitable treatment under a reimbursement plan which utilizes DRGs.

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February 4, 1983

Mr. Robert E. Lighthizer
Chief Counsel
Committee on Finance
Room SD-221
Dirksen Senate Office Building
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Dear Mr. Lighthizer:

This letter is our written statement on hospital prospective payment systems, the subject of your recent hearing on February 2, 1983. Basically, we are in support of the position of the Association of American Medical Colleges on this issue; however, there are some areas of special concern to us.

The proposal states that the problem of a hospital with an unusual number of severely ill patients is taken care of by 1) cost averaging, 2) allowing for "outliers" (patients with an unusually long length of stay), and 3) allowing for a pass-through of direct and indirect educational costs for teaching hospitals. We are concerned that such methods are not sufficiently sensitive to take account of the level of severity within diagnosis-related groups (DRG's) served by tertiary hospitals. While the outlier approach will take care of unusually long lengths of stay, it will not take care of the case of severely ill patients who require a disproportionate amount of resources, but do not require a long length of stay. Nor, we believe, does averaging accurately reflect such severely ill patients; indeed, averaging understates the cost of tertiary care, and overstates the cost of routine care. Some sort of mechanism must be devised to take care of severity within a DRG, or alternatively, the DRG's must be devised on a hospital-by-hospital basis.

While we support the concept of a pass-through for indirect educational costs, no mechanism for computing the lump sum payment for such costs is given in the proposal. Until such a mechanism is given, we cannot be sure the lump sum payment will fully and equitably reflect teaching costs.

As a major academic medical center in the Northeast, we are concerned that the proposal does not adequately deal with regional variations. While the proposal does allow for the adjustment of national DRG's by area wage differentials, it does not allow for wage adjustments between center-city and suburban areas, nor does it allow adjustments for high operating costs in areas with aging facilities and severe climates like the Northeast.

A teaching hospital of Boston University School of Medicine
and a member of Boston University Medical Center

Massachusetts is currently operating under a Medicare waiver as part of a package of reimbursement mechanisms contained in Chapter 372, as passed last year by the Massachusetts legislature. We urge that experiments such as ours be allowed to continue long enough to adequately test what is the best method of prospective payment. While the HHS proposal has many features which are sensitive to hospital needs, it does not answer all questions; indeed, such questions cannot be answered except by testing a variety of approaches. We urge that explicit provision allowing and encouraging such experiments be built into any prospective payment system.

Finally, we are concerned that the proposal contains no mention of any administrative appeals mechanism by which to correct arbitrary, or mistaken decisions. To say, as the proposal does, that the remedy for a provider dissatisfied with the rate offered is to convince the purchasing agency that a higher rate is appropriate, or, failing that, to drop out of the Medicare program, is hardly conducive to complete confidence in the mechanism for obtaining redress. Some sort of administrative appeals mechanism must be built into the system.

We appreciate the opportunity to offer our views, and stand ready to provide any specific information which might be of help to the Committee.

Sincerely,

J. Scott Abercrombie, Jr., M.D.
President

JSA/AR/cmc